The Canadian Nurse

Registered at Ottawa, Canada, as second class matter.
Editor and Business Manager:
ETHEL JOHNS, Reg. N., 1411 Crescent Street, Station H, Montreal, P.Q.

CONTENTS FOR OCTOBER, 1943

Subscription Price: $2.00 per year; foreign and United States of America, $2.50; 20 cents a copy. Cheques and money orders should be made payable to *The Canadian Nurse*. When remitting by cheque 15 cents should be added to cover exchange.

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Reader's Guide

At the time of writing the desperate struggle for Salerno is still in progress and there is a rumour that our Canadian troops are **On Active Service** and are taking part in it. Censorship makes it impossible to give as much news as we should like about our Nursing Sisters and we have to rely on such shreds and patches as we can weave into a more or less coherent story. In so doing, we acknowledge our growing debt to the Department of Public Relations (Army) for its kind co-operation.

The Wartime Prices and Trade Board is still exercising firm control over the amount of paper we may use but nevertheless the Board does give the *Journal* a fair deal. If we can meet **The Acid Test** and show a rising circulation, our ration goes up proportionately, and it is heartening to know that all the Provincial Associations of Registered Nurses are determined to help us come through with flying colours. Perhaps you are asking your friends to subscribe and are meeting with sales-resistance. In that case, the leading article in this issue may give you aid and comfort. Anyway, you will know that you have our sympathy. It couldn't be (or could it?) that *you* yourself don't yet meet the acid test. If so, listen to the voice of conscience and send in two dollars (or even one) today.

Blood transfusion has brought about such amazingly good results that we cannot learn too much about it. Certain conditions affect its use in the treatment of pregnant and parturient women and **Dr. Madge Thurlow Macklin** gives a most interesting outline of what is known as the Rh. Factor. Dr. Macklin is assistant professor of histology and embryology in the University of Western Ontario.

The desperate shortage of doctors and nurses, especially in the rural areas, often makes it necessary nowadays for nurses to deliver maternity cases. The series of articles written by **Caroline V. Barrett** and her associates on various aspects of obstetrical nursing will prove useful in dealing effectively with such emergencies.

Adrift in a Life-boat is an epic story told with utter simplicity by Doris Hawkins, a graduate of the Nightingale School of St. Thomas's Hospital, London. Calmness, courage and restraint are chief among the nursing virtues. Our British sisters possess them in full measure.

If you should happen to need an antidote for an attack of self-pity, just read the story told by **Mary McNee** about one of her patients who faced up to a blow that would have crushed a less gallant spirit. Miss McNee is a private duty nurse and lives in Ottawa.

The R.C.A.M.C. Nursing Sister who has the place of honour on the cover of this issue of the *Journal* is all dressed up and ready to go wherever she can best **Speed the Victory.** She was in Sicily when the picture was taken but by now that Army jeep may have carried her fast and far toward the new line of battle.

In *Notes from the National Office* there is evidence that the **International Council of Nurses** is once more beginning to function. The Council has survived one Great War and seems likely to survive another. There is an indestructible quality about nursing organizations that no amount of adversity seems able to overcome. No matter how hard you hit them, they come up gamely for more. It may be years before the nurses of the world take council with one another but even now the first slender threads of communication are being woven that will bring us into touch again.


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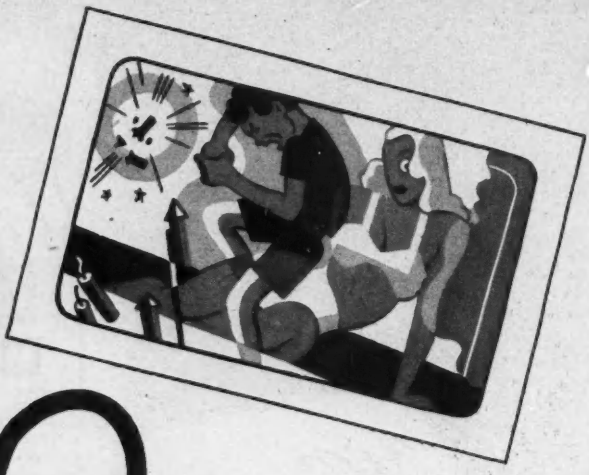

1. Summertime doubles exposure to numerous risks: (*a*) Many will bathe too long in the burning rays of the sun, get too close to campfires and hold fireworks too long, exposing themselves to the double risk of painful burns and dangerous infections. (*b*) Others will suffer cuts, abrasions and minor lacerations that often go with strenuous participation in outdoor sports.

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The
CANADIAN NURSE

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The Acid Test

At the time that rationing of newsprint was first imposed, the Wartime Prices and Trade Board asked for evidence that this *Journal* renders sufficient service to justify the allocation of a fairly generous quota. In other words, it was necessary to convince the Board that the *Journal* is actually worth the paper it is printed on. That question rather set us back on our heels. We had always taken for granted that, in spite of all its faults, the *Journal* does serve some useful purpose but, when we tried to define its worth in coldly objective terms, we were seized with misgivings. The only proof that the Board would accept as valid was a sworn statement of circulation that showed a steady and consistent rise over a given period of time. This was to be the acid test that would demonstrate that the *Journal* is (or is not) useful to the Canadian Nurses Association.

Although the *Journal* measured up to this initial test, the Board made it perfectly clear that the prevailing quota is in no sense permanent but is subject to revision every three months. Future allocations will continue to be made in direct relation to circulation and will rise or fall with it. At the June meeting of the executive committee of the Canadian Nurses Association, the whole situation came up for discussion and every Provincial Association of Registered Nurses (except one) undertook to obtain a given number of subscribers. The solitary exception was Prince Edward Island, and the reason that the Island didn't take the pledge was that so large a proportion of its nurses already are subscribers that new ones would be hard to come by. Six Provincial Associations have taken active measures to fulfil these pledges and the Registered Nurses Association of Nova Scotia has already reached and passed its objective and is still going strong. New Brunswick and Alberta are making excellent progress and a good

start has been made in Saskatchewan and British Columbia. The Manitoba Association of Registered Nurses has made the grim decision that, if they can't corral sufficient more or less voluntary victims, the Association will underwrite the pledge.

Letters have been received from different parts of the country asking for suggestions that might be useful in working up the campaign. During the past eleven years, our supply of bright ideas along these lines has been seriously depleted. However, we proceeded to beg, borrow and steal and, by sheer luck, got hold of a brochure, written by Dr. Stephen Leacock, in which he tries to persuade the alumni of McGill University to join the Graduates Society. It was a great comfort to find that even such an august and plutocratic group evidently has trouble in persuading potential members to fork out the modest sum of three dollars. It seems that they all love dear old McGill. Of course they do, but not to the extent of giving any tangible proof of their affection.

It was at this point that Dr. Leacock moved us to tears. We knew from bitter experience just how he felt when he wrote that brochure. We are frequently assured that the Canadian Nurses Association couldn't get along without "the good old *Journal*". Yet strangely enough, the names of these staunch supporters are sometimes missing from the mailing list. Evidently the full measure of their devotion doesn't quite add up to two dollars. About all that can be done is to suggest that lip service is not enough. If you keep right after them, they sometimes come through with a dollar for a six-months trial subscription, thus adding another name to the list that determines the size of our next quota of paper. The hardest nut to crack is the superior damsel who doesn't subscribe to *The Canadian Nurse* because it isn't as good as the excellent publications that appear south of the border. One has to admit that the woman is right. The *Journal* isn't in the same class and doesn't claim to be. Every up-and-coming nurse in Canada ought to subscribe to the American nursing journals. She will miss a lot if she doesn't. Yet there are a few things that she will find only in the nursing journal of her own country. It is there that she must turn to discover what Canadian nurses are thinking about, talking about, and striving to accomplish.

It has been the writer's inestimable privilege to work in eleven different countries and thus to observe the profound influence that each national culture has on nursing. There is something unique in the conception which animates each national nursing group. No two are alike. Each has something precious that is peculiar to itself.

It is not easy to discern the specific values that are inherent in our Canadian way of life because they are sometimes thrust into the background by the sheer impact of the good things that come to us from beyond our own borders. Nurses, like other Canadians, sometimes share the inferiority complex that crops up in small national groups living in close contact with large ones. This defeatist attitude has hindered the development of a truly Canadian culture, especially in the field of literature and art. In the field of journalism, its influence is so marked that the editor of a well known weekly magazine has feelingly remarked that if any journal is to survive at all in Canada "it must be dammed Canadian and dammed good". While deprecating the violence of the gentleman's language, we are forced to admit that it sums up in a single phrase what we think the *Journal* is going to be some day—provided it can meet the acid test.

—E. J.

Canadian Army Photo

R.C.A.M.C. advanced medical station in Sicily

On Active Service

Under the stress and strain of modern war, amazing advances have been made in the care of the wounded. The rapidity with which military operations are now conducted is so great that the medical services have had to devise new methods in order to keep pace. Transportation of the wounded in from the battlefield to base hospitals has been enormously speeded up by means of evacuation by air and early in the North African campaign the British Army established mobile surgical units that push up close to the front lines and thus spare the wounded soldier the pain and fatigue of a long journey on a stretcher to a clearing station situated some distance behind the lines.

In the Russian army, medical orderlies go out singly while the fighting is still in progress and bring in wounded men on their backs. Many of these orderlies are women and some are dropped by parachutes from planes. There are many casualties in their ranks but an amazing number of them do get through and the wounded men receive treatment much earlier than was the case in the last war when they had to wait for stretcher bearers who usually were obliged to wait until night before they could begin their rounds.

According to a statement released from the United Kingdom Information Office, the war has also had a profound effect on military nursing service. In this war the hard-and-fast line between soldier and civilian has been wiped out. The field of battle now extends far to the rear of the front line—the chief characteristic of what is called "total war". Elimination of the borderline between soldier and civilian, between battle zone and safety zone, has brought with it many and significant consequences. One is that the distinction between civilian and military hospitals has practically ceased to exist. Hundreds

of miles away from any front, a large infirmary may find itself quickly transformed into a military hospital. Ever since the outbreak of war, many hospitals in Britain have kept special wards ready to receive the casualties caused by air raids. Many wounded soldiers who came back from Dunkirk were nursed in civilian hospitals by nurses who till then had scarcely dreamt of finding themselves in direct contact with the war.

British nurses have indeed taken their share since those days and for more than four years have worked willingly and ceaselessly, never for an instant considering or sparing themselves. Foremost among them were the civilian nurses who, during the heavy air raids of 1940-41, gave just as splendid proof of courage and self-sacrifice as any war veteran. It was not an easy task to carry on through the long nights of that autumn and winter, when ambulances kept bringing in casualties, while bombs burst on all sides and night was lit by burning buildings. The hospitals themselves were often a target for German bombs. Today, British nurses are to be found throughout the Middle East, in Egypt and the Sudan, in Palestine, Syria, Irak and Persia. You even come across them in such remote parts of the world as East Africa, Mauritius, and West Africa.

After a long and weary interval of waiting, the Canadian Fighting Forces are at last taking their places in the front line. Canadian military Nursing Sisters are now on duty in Sicily and in North Africa and although we shall have to wait for the complete story of their adventures the veil of censorship does lift occasionally and allows a glimpse of what is going on behind the scenes. Thanks to the courtesy and co-operation of the Public Relations Department (Army) the *Journal* is privi-

Canadian Army Photo

R.C.A.M.C. improvised field hospital in Sicily.

Canadian Army Photo

R.C.A.M.C. Nursing Sisters attached to a medical unit in a Sicilian town.

leged to publish the extremely interesting photographs which illustrate this article. One of these shows a Canadian advanced medical station in Sicily. The personnel of the unit have settled down in their appointed location and done a little family washing while standing by in readiness to attend to casualties when they arrive. Apparently Nursing Sisters are not assigned to duty in these advanced stations although we shouldn't be surprised to hear that they may be before long. Another illustration shows a ward in an improvised field hospital in Sicily, directed by the Royal Canadian Army Medical Corps. The ward is so crowded that beds must be placed down the middle, a state of affairs that must complicate the nursing service rather severely. Yet another picture shows a group of R.C.A.M.C. Nursing Sisters enjoying a brief rest in a building in a Sicilian town that was requisitioned for use by a medical unit. There appears to be a beautiful piece of tapestry on the wall but loot is a deadly sin in the Army.

Two R.C.A.M.C. Nursing Sisters are prisoners of the Japanese in Hong Kong. They are Nursing Sister Kathleen Christie of Toronto and Nursing Sister Anna May Walters of Winnipeg. So far as is known, they are still on duty in a hospital in which sick and wounded Canadian soldiers are being cared for and can proudly tell their captors "Stone walls do not a prison make, nor iron bars a cage."

Even on the home front there is plenty of opportunity for adventure and a recent release from the Public Relations Department proves that nurses turn up in all sorts of unexpected places. It seems that Nursing Sister Verda Smith is currently touring Canada with "The Army Show", and her main job is to see that the men and women of the all-army cast are in perfect health at all times. "There are times when over-enthusiastic artists want the show to go on, regardless of their health", says Nursing Sister Smith, "but the Army doesn't agree. Consequently, I have the final word as to whether a

performer shall be allowed to take part in the show, if a matter of health is involved. The most common ailment among the cast has been sore throats. We've had a few cases of influenza as well as the usual run of cuts, bruises, sprains, and other minor injuries. I've managed to treat most of the cases in my well-equipped portable sick bay, but, of course, any serious cases of illness would always be turned over immediately to the competent army medical authorities at one of our frequent stopping places where the show is playing".

In addition to treating the personnel in case of illness, Nursing Sister Smith checks the daily diet sheets for the "Army Show" kitchen, supervises the cleanliness and sanitation arrangements, and keeps a complete record on all cases of ill-health among the men and girls of the show. "Discipline and proper planning of meals and living habits make for a definite improvement in health", says Miss Smith, who has had an opportunity of seeing the betterment in health among the cast since the show started its cross-country trip. Her daily tour of duty begins at reveille and isn't over until the curtain is rung down after the evening performance. Every night Nursing Sister Smith is backstage, ready for any emergency sickness or accident which may occur.

Some Aspects of Obstetrical Nursing

CAROLINE BARRETT, OLGA LILLY BARWICK
GERTRUDE YEATS

A detailed study of the nursing care of a patient during a normal labour cannot be adequately undertaken within the limits of a brief article. During her clinical experience, the student nurse will have an opportunity of learning a great deal about the management of uncomplicated delivery and, with the help of text-books and class review, can acquire sufficient knowledge to afford a good background. There are however one or two points that are sometimes overlooked and that we shall therefore mention in passing.

Labour is a long and tedious process and the nurse can do much to help the patient, epecially during the earlier stages. Above all she should remember that fear is very exhausting and that it increases suffering. Encourage and reassure the patient and teach her to rest between her pains; tell her not to bear down until she feels instinctively that she must do so. During the first stage of labour, teach her to breathe quickly through her mouth during her pains since this will favour relaxation. During the second stage, after the cervix is fully dilated and the presenting part of the foetus is advancing, teach her to bear down with each pain, thereby hastening her delivery. Tell her to draw a deep breath as the pain begins, to hold it and to force downward and backward (as for defecation) as long as the pain lasts. When the pain is over persuade her to relax completely and to rest until the next pain begins.

The nurse must consider the following factors when deciding the time that the physician should be called: whether the patient is a primi-

para or a multipara; the history of past labours; the rate at which labour has been progressing and whether there are signs that birth is imminent; whether there are signs of failing strength; whether the child is relatively small or large as compared to the pelvic canal and whether there are any signs that it is suffering; the length of time that the physician will need to reach the patient after he is called; and whether he wishes to be present before he is actually needed.

Under ordinary circumstances, labour will proceed normally and complications will not occur. Nevertheless, the nurse must know their general nature and cause, their signs and symptoms, and what measures must be taken to deal with them. The remainder of this article will be devoted to a brief discussion of some of the complications which might possibly present themselves.

Rupture of the uterus may occur during labour. The warning symptoms are (1) the uterine contractions (labour pains) are unusually strong and frequent; (2) there is no advancing of the foetus through the pelvic canal; (3) in some cases the patient complains of pain in the intervals between her "pains"; (4) the uterus is hard, except at the place where the rupture will occur, usually just above the pubes; at this point it is soft and tender and the patient instinctively supports the part with her hands; (5) there may be a bulging of the uterine wall, resembling a full bladder. When a rupture has occurred, the following symptoms and signs may be present: a sudden, sharp, abdominal pain and then no further pain; profuse, internal bleeding, as evidenced by the rapid onset of grave systemic symptoms of blood loss; depending upon the extent and the location of the rupture, parts of the foetus may protrude through the opening in the uterine wall and may be palpated; the foetal heart cannot be heard or if heard, the beats soon cease. The physician must be called and morphine gr. ¼ must be administered at once. If vaginal bleeding occurs, apply sterile pads held firmly with a T-binder, apply external warmth, and give warm fluids by mouth. Prepare for an immediate laparotomy—this is imperative and urgent. Be ready to deal with an extreme case of haemorrhage and collapse.

Prolapse of the umbilical cord is an obstetrical complication in which the cord slips down beside or beyond the presenting part. If the membranes have ruptured it may appear in the vagina or at the vulva. Prolapse may occur under any of the following conditions: (1) when there is a small baby in a roomy pelvis; (2) in breech presentations; (3) when the membranes rupture and the presenting part is not engaged; (4) following the expulsion of the bag in a bag induction of labour; (5) when the mother's pelvis is flattened antero-posteriorly, thus allowing too much room at the sides. Earlier symptoms are present when the foetus is suffering. The foetal heart-beat taken between pains may be (a) over 150 per minute; (b) under 120 per minute; (c) irregular in rate and rhythm; (d) diminishing in volume. Except in breech presentations, the passing of meconium denotes foetal distress. The loop of umbilical cord in the vagina can be felt upon rectal or vaginal examination. A later sign is the appearance of the cord at the vaginal introitus. Emergency nursing care is as follows: (1) notify the physician; (2) elevate the mother's hips above the level of her shoulders; (3) if she is wearing an abdominal binder, remove it at once; (4) do not allow her to bear down with her pains. If the baby is living, give a little chloroform during each uterine contraction to check its force and lessen the pressure on the cord. If the cord is exposed, sponge it with warm antiseptic solution and with sterile gloved fingers push it

gently back into the vagina (to keep it warm) and then firmly apply sterile vaginal pads and a T-binder to prevent its escape. Have everything ready for immediate delivery.

Forceps delivery implies that certain requisites must be fulfilled: (1) the cervix must be fully dilated; (2) the outlet of the bony pelvis must be ample; (3) the rectum must be empty; (4) the bladder must be empty; (5) the child must be alive; (6) the presentation, position and posture of the foetus must be known; (7) the head must be engaged in the pelvis; (8) the membranes must be ruptured; (9) the soft parts (vagina and perineum) must be manually dilated or "ironed out"; (10) the mother must be on a table that is firm, immovable and conveniently high; (11) the floor where the physician will stand must be dry; (12) the light must be good and be directed on the field of operation; (13) the mother must be anaesthetized; (14) surgical asepsis must be rigidly observed. The nurse actively participates in fulfilling Nos. 3, 4, 10, 11, 12 and 14.

A complete, or third-degree tear, extending through the sphincter muscle into the rectum, may be caused by overstretching the vaginal orifice and perineum during delivery. This is more apt to occur when delivery is rapid than when it is gradual; also when the head measurements are greater than normal or the vaginal orifice is small. Protection of the perineum is carried out in each delivery by preventing unnecessary strain and too rapid delivery. An episiotomy is usually done to prevent a complete tear. The success of the repair depends largely upon the after-care of the patient, and this care is principally nursing. Prevent strain on the wound by keeping the patient's knees together until she is out of anaesthesia. She should be taught to refrain from spreading her knees widely apart and from straining at the rectum at any time. Ask the patient to inform her nurse if she feels the desire to defecate; the physician sometimes leaves an order for her to be given morphine gr. ¼ under these circumstances. She must not be allowed to sit up in bed until given permission and, if she inquires the reason, she should be told that she has had to have some extra stitches put in and that strain on them must be avoided so that she will heal well. Every effort should be made to assist the patient to void urine but if unable to do so she may have to be catheterized. In the presence of bladder distress, an irrigation with mild antiseptic solution, followed by an instillation of a mild antiseptic, may be ordered. For the first week after operation it is desirable to check peristalsis by means of appropriate medication. The bowels may be allowed to move 5 to 10 days after operation depending upon the degree of repair. The orders vary with respect to cathartics and enemata. The usual order is a dose of bland oil by mouth in the evening followed by a warm oil enema in the morning; this softens the content of the bowel. The patient must not be allowed to strain as this may cause the breaking down of tissue. When giving the enema a soft rubber catheter is preferable and should be inserted slowly, directing it against the posterior rectal wall, away from the newly repaired anterior wall. Watch carefully when the bowels are first opened and for a few days following for any signs of the presence of a rectovaginal fistula. Cleanliness and dryness will favour healing and the usual post partum genital cleansing is given with particular care to guard against infection and any strain on the wound. The perineum may be exposed to dry heat for about 20 minutes three times a day by means of a 25 watt electric lamp and reflector. Vaginal pads are removed during this treatment. Stay sutures, when used, are not removed until after the bowels

are opened. Careful attention should be given to the patient's diet. Clear fluids only should be allowed during the first 72 hours after operation and fluids only for the ensuing 48 hours. During the succeeding 48 hours the patient may have soft, low residue food, and may be given full diet on the eighth post-operative day or after the bowels have been opened.

Primary postpartum haemorrhage may occur during the first 24 hours after delivery. This is due to bleeding from the placental site and may occur when the uterus fails to contract or the contractions are very feeble. The symptoms and signs are: the fundus uteri is soft, large, and unusually high in the abdomen; pressure on the uterus, or any exertion on the part of the patient, results in a copious flow of dark, clotted blood from the vagina; systemic symptoms of blood loss are soon manifested. If the bleeding has been caused by lacerations, a continuous stream of bright, red blood flows from the site of the injury, most commonly in the cervix but possibly in the vagina or the perineum. The physician should be called at once and the patient reassured. The nurse should locate the fundus uteri and exert firm, downward pressure on it to express any free blood in the uterus. If the uterus is relaxed, knead it until it contracts and then maintain firm, downward pressure on it. With the other hand, place sterile pads over the vulva and exert firm upward pressure. If the uterus again becomes relaxed, remove the pressure from the vulva, express any free blood in the uterus, knead it until it again contracts, and resume the pressure from above and the counter-pressure from below; maintain this pressure until the uterus remains firmly contracted. Appropriate doses of pituitrin or some form of ergot should be given hypodermically as soon as possible. See that the bladder is empty and, if in doubt, catheterize at once. Apply external warmth, raise the foot of the bed and, if indicated, bandage the patient's legs and thighs so as to help maintain the supply of blood to her heart and brain. For severe bleeding and restlessness give morphine gr. ¼. Blood plasma or transfusions or saline intravenously may be administered to relieve systemic symptoms. If lacerations are present, the obstetrician will repair them and, if a portion of the placenta has been retained, it may be necessary to remove it immediately despite the danger of infection; every effort will be made, however, to minimize this danger.

Secondary postpartum haemorrhage may occur even after the first 24 hours has elapsed. Vaginal bleeding will be present, accompanied by symptoms of blood loss. There may be subinvolution and tenderness of the uterus. The physician should be called at once. Infection is the likely cause of bleeding and, therefore, the uterus should not be handled. Keep the patient absolutely quiet and raise the foot of the bed from 2 to 3 feet. Reinforce the vaginal pads and see that the T-binder is tightly applied. Pituitrin and some form of ergot should be administered as soon as possible. If the bleeding is severe and the patient is restless give morphine gr. ¼. See that the bladder is empty and, if necessary, catheterize. Because of the danger of infection, an internal pelvic examination or operation is contraindicated (except in extreme cases) for the present. Later, if the presence of placental tissue in the uterus is suspected, an operation may be performed but not until it can be done with safety.

Puerperal infection is an infection connected with pregnancy and labour and is important because of its high mortality. The predisposing causes are those which lower the patient's resistance: anaemia, poor health generally, exhaustion, trauma, loss of blood, the

presence in the uterus of retained placenta or blood clots. The symptoms are those associated with any febrile disease: headache, general malaise, fever, rapid pulse, also tender subinvoluted uterus and abnormal lochia. The symptoms vary with the severity of the infection. The general treatment includes the strict observance of isolation and medical aseptic technique. Mild sedatives may be given to relieve pain and induce sleep. Though she should have fresh air in abundance, the patient must not lie in a draft or become chilled. Blood transfusions are given whenever it is advisable rapidly to raise her resistance and to keep her haemoglobin as near as possible to 100%. Sulphanilamide (prontylin) may be ordered in varying doses for three days as indicated by the blood analyses. Vaccines and sera may be given in some cases depending on the types of organisms found in the cultures taken from the blood and lochia. Forced fluids should be given and the patient should take light nourishment often; tonics to improve the appetite and aid recovery are frequently prescribed. Vaginal drainage is promoted by keeping the head of the bed elevated day and night. The genitals are cleansed with an antiseptic solution after micturition and defecation. There must be no unnecessary handling of the infected parts and all handling must be very gentle. A change of position should be made from time to time without causing the patient any exertion. Heat or cold may be applied to the abdomen continuously or at intervals as ordered. Nursing the infant is not permitted while the general symptoms of infection persist; whether or not it may be permitted later depends upon the severity of the infection, the general health of the patient, her response to treatment, and whether she is likely to have enough milk to justify her efforts. Whenever it is evident that nursing should not be attempted, the breasts are dried up.

In the past we may not have given enough thought to the trying time the young mother has to face when she reaches home. Perhaps we have been unable to formulate a definite plan of action, not because we did not realize the importance of this teaching, but because, like Martha, we were cumbered with much serving. There are great possibilities of service in a maternity ward, as well as great responsibilities, and the greatest of these is the instruction of the young mother in the care of her new-born child. When should the patient be taught to bathe and handle her intant? Without a doubt, while in hospital, and again without a doubt this is a most difficult thing to manage, especially at a time when there is a shortage of staff. Speaking from experience, it seems a relatively easy matter to plan to teach the mother in a small unit, but in a large department the effort seems greater, and the obstacles more numerous. Still, in spite of the difficulties, the problem must be solved and the mother taught at least how to bathe her child.

It is while the nurse is taking her obstetrical training that her sense of duty and her responsibility to the future generation can best be aroused. It rests with us to see that the experience and training received in this branch of nursing is such that it will enable her to understand and appreciate the mystery and beauty of the renewal of life, as well as to realize that a nation's greatest asset is the health of its people.

Jean Wilson Retires

Our National Office will seem strange, indeed, with the kindly, gracious personality of Jean Wilson withdrawn from it. She has been its presiding genius for more than twenty years and has become inextricably linked up with its development. In the hearts and minds of Canadian nurses she has a place which is peculiarly her own and ties of friendship, knit through years of close, intimate contact with young and old, will long remain.

To recall her professional career is to go back into the history of organized nursing. Possessed of a challenging, pioneer nature she has always been found at the forefront of new effort to which she has given untiringly of her interest and enthusiasm. As a young, alert superintendent of a Saskatchewan hospital, she was one of the prominent figures in the struggle for registration and her name appears in the Nurses' Act as a charter member. For the first three years of the Saskatchewan Registered Nurses Association, she served as its secretary-treasurer, carrying as a voluntary service an office replete with the multitudinous and often irksome duties peculiar to a new organization. She left her definite imprint upon it in well ordered records, her legacy to those who came after.

When the Canadian Nurses Association reached the status of a full-time executive officer, the immediate and unanimous choice was Jean Wilson, the wisdom of which choice has been proven by the years. The difficulties attendant upon a task have never been a deterrent to her. She has, in fact, welcomed them. It was no simple matter to set up and organize a national office in the mid-west, nor was it simple some years later to tear up the roots so laboriously put down and transfer that office to the east. It was no simple

JEAN S. WILSON

matter to step into the breach and serve as editor of a professional journal, on short notice and with no special preparation for it. Yet these are only a few of the enormous undertakings which she has carried through to success. She has been a part of all the various studies, projects and activities which the years have brought to the Canadian Nurses Association and has provided the background without which sections and committees might have functioned with difficulty. As a loyal, friendly guide to the inexperienced, there are many who have just cause to remember her for help and encouragement freely given. Possessed of a particularly keen sense of order and detail, she has conducted the business of the Association with a meticulous care which has won for her the admiration of all. A shrewd busi-

ness woman, she has, beyond a doubt, been responsible to a great extent for the splendid financial situation in which the Association now finds itself.

It would require a history of the Canadian Nurses Association to even list the achievements of its first Executive Secretary. The Association has been her life and her single purpose has been an organization in keeping with a great profession. The standard she has set will be a challenge to those who follow. Miss Wilson retires now, at her own request, to the enjoyment of plans which she has made for her leisure days. Surely the warmest thoughts of Canadian nurses will follow her and the courtesy and consideration, which have at all times marked her contact with others, will remain as vital a memory as the efficiency and skill with which she performed her duties. May her cup be filled with happiness and satisfaction — full measure, pressed down and flowing over.

—Ruby M. Simpson.

The Centenary of Rebecca Strong

During the month of August 1943 Rebecca Strong reached and passed the century mark. As *The Nursing Times* points out, this year also marks the fiftieth anniversary of the preliminary training school which she inaugurated at the Glasgow Infirmary, the first to be established in Britain. Mrs. Strong entered the Nightingale School of St. Thomas's Hospital in 1867 and later was a member of a group of six nurses sent by Miss Nightingale to reorganize the nursing service in the Military Hospital in Netley. In 1879 she was appointed matron of the Glasgow Royal Infirmary and carried on a vigorous campaign for improvement in the working and living conditions of the nursing staff. When, however, she insisted on the provision of a suitable residence, the authorities felt that she was going much too far and refused her request. Mrs. Strong promptly resigned but, after an interval of six years, was re-appointed and remained in office until she withdrew from administrative work at the age of sixty-four.

As soon as she was free from her hospital duties, Mrs. Strong diverted her energies to the educational field. To quote *The Nursing Times*:

Mrs. Strong drew up and inaugurated a scheme of nursing training involving a definite syllabus which included lectures in anatomy, physiology and hygiene, given by lecturers belonging to St. Mungo's College, and by the medical and surgical staff of the hospital. A second course, which was more advanced, included lectures and clinical demonstrations in surgery and medicine, and also nursing lectures and practical demonstrations given by Mrs. Strong herself. Apart from professional tuition and study, Mrs. Strong held readings and study meetings with nurses, initiating them into the poetry of Browning and the prose of Carlyle.

Mrs. Strong was an arresting figure at many international conferences and in 1929 attended the International Congress of Nurses in Montreal. Although she had then attained the age of 86 years her lively wit and keen insight into modern nursing conditions were as remarkable as ever. "Age could not wither her, nor custom stale her infinite variety".

Among the most treasured possessions of this *Journal* is a syllabus of the course given at St. Mungo's College to which

reference has already been made. The marginal notes are in Mrs. Strong's own handwriting, clear and firm as ever. The envelope in which the syllabus came is marked "Passed by Censor" and reached the *Journal* office on July 21, 1941, having braved the perilous seas. In acknowledging this priceless gift, we wrote: "Your plans for the various courses are just as sound as they were when you first made them almost fifty years ago. Canadian nurses will never forget that the idea of the preliminary course originated with you and that it contained the germ of all that was to follow."

An Appointment to National Office

Florence Harriet Walker has been appointed assistant to the general secretary of the Canadian Nurses Association and, by the time these lines appear in print, will have assumed her new duties in the National Office.

Miss Walker is a native of Ontario and received her academic education in that province. She is a graduate of the School of Nursing of the Hamilton General Hospital and won a prize, awarded by the Board of Governors, that enabled her to undertake post-graduate study. After completing the diploma course in teaching and supervision given by the School for Graduate Nurses, McGill University, Miss Walker served for three years as instructor in the School of Nursing of the Hamilton General Hospital. She then joined the training school office staff of the Vancouver General Hospital and later was appointed supervisor-in-charge of the Infants Hospital. During her stay in Vancouver, she undertook further study at the University of British Columbia leading to the degrees of B.A. and B.Sc. (Nursing). Prior to joining the staff at National Office, Miss Walker was in charge of a summer probation course specially organized for the benefit of the first group of students to enrol at McMaster University in the newly established course in nursing.

Miss Walker has been actively associated with the work of various nursing organizations and served for four years as the secretary of the Registered Nurses Association of British Columbia and for six years as a member of the council. She is a woman of many interests and is a member of the University Women's Club; her special hobby is motoring in search of beautiful scenery. The fortunate possessor of so many qualifications and such broad experience, Miss Walker cannot fail to succeed in the challenging task she has now undertaken.

Photo by Hubert Beckett

FLORENCE H. WALKER

Adrift in a Life-boat

Doris M. Hawkins

I was travelling to England bringing with me Sally, aged fourteen months, the infant daughter of a friend who was also my patient when Sally was born. When the Battle of Egypt brought Rommel's forces within 50 miles of Alexandria I was asked whether I would take Sally home to my friend's parents. So we started on our long voyage. On the night of September 12, I came up from dinner and as usual looked at Sally. She was asleep. Usually I went up to the next deck, and remained in the lounge for an hour or two but G. . ., my friend, was unwell and in bed, and so fortunately I went into her cabin which was opposite to mine. I had been in there about two minutes when the first torpedo struck us. It was the most sickening sensation—the whole ship shivered and stood still, and the air was filled with the smell of explosive.

I fled to Sally, who was still asleep, wrapped her in her woollies, picked up her emergency bag, and turned as the second torpedo struck us. We were thrown across the corridor but Sally remained in my arms and was unhurt. G . . . was just ahead of us, and we made our way upstairs as the lights failed. The ship had a terrific list, and it was very difficult going with my precious burden. We stumbled over broken woodwork to our boat station but our life-boat had been blown away. It was pitch-dark, and had it not been for Squadron-Leader W., I should probably have gone down with the ship. He took us from boat station to boat station, but many boats had left or were jammed or full. Finally, nearly three-quarters of an hour after the torpedo had struck, a Naval Officer (passenger) tucked Sally down the back of his great-coat, tied a blanket round his waist just under her foot level to prevent her from slipping, and carried her, papoose fashion, down a swinging rope ladder, followed by G . . . and myself into a crowded life-boat which was heaving and tossing like a cork. The life-boat was rapidly filling with water and at the same time crashing against the ship's side. Just as Sally was passed over to me the boat filled completely and capsized. She was flung away from me and I lost her and I never saw her again.

I found myself among numbers of Italians (prisoners of war on board the ship), screaming and struggling in the water. Finally, I came up against a raft to which I clung. There were already four Italians hanging on to the sides and they helped me up on to the top of the raft. I lay there and we drifted away from the ship. When about 150 yards away, I saw the ship rear half out of the water and then she sank like a great monster, hissing and roaring—a dreadful and awe-inspiring sight.

Suddenly I heard the voice of Squadron-Leader W. calling out to find whether there were any more English people about. I answered him and he swam towards me. At that moment the ship's boilers exploded with terrific force, and I felt a sickening pain in my back, while Squadron-Leader W. just crumpled up as we reached their raft. Judging from his subsequent symptoms I think he had internal haemorrhage. On reaching this second raft I was hoisted on top. There were then nine or ten men clinging to the sides of the raft. Later we put the Italians on to an Italian raft, leaving us all British. We had all swallowed a good deal of thick oil from the wreck and

sea water, and we were all violently sick.

Throughout the long night the men took turns to sit beside me for ten minutes at a time. They were terribly cold in the water, and I was terribly cold out of it. My wet clothes clung to me and I shivered and longed for dawn. We saw lights from time to time which we took to be from our life-boats, but they were a long way off. All through the night the mournful cry for help rose in a wail from the Italians wherever they were. We met another raft or two carrying men and women, and we passed doors, orange boxes, oars, pieces of wood large and small, with men clinging on desperately and crying for help. When at last dawn came, there was a fairly high sea, and only occasionally did we glimpse another raft or boat as we rose on the crest of a wave. The sun came up and warmed us; it came higher and scorched us, and by mid-day an equatorial sun was blistering our arms, legs faces and every exposed surface. We were not hungry but terribly thirsty. An Army captain shared his emergency chocolate ration with us. An orange floated by — someone grabbed it, we divided it and chewed the peel for hours.

During the morning, the German submarine which had torpedoed us passed within two hundred yards. It stopped about half a mile away and we were drifting in the same direction. We came up to a raft with two R.A.F. officers and one Italian, and joined them to our raft with a rope. We were now nine people on two rafts. One or two of our men had already become too exhausted to hold on any longer and had dropped off into the sea. Around us in every direction now were corpses and wreckage, and quite a number of survivors on rafts and pieces of wood.

All day we saw the submarine moving around from place to place, and once we saw people being pulled on board by a life-line. This made Squadron-Leader W. decide to try and make for the submarine. Normally he was a magnificent swimmer and, summoning all his strength, he tied a tow rope around his body and struck out, towing two rafts and nine people. When we were within a few hundred yards the submarine set off in another direction and we just drifted round for the rest of the day. The sun was low when a second submarine appeared, cruised around and then submerged. The sun set, and we began to dread a second night, when suddenly the first submarine turned and came straight towards us, threw us a life-line and took us all aboard. We could scarcely stand, and I was taken to the officers' room where, to my joy, I found G . . ., who had been picked up five minutes before. Altogether two hundred people had been picked up and put into our life-boats, and when these were full the remainder of the survivors, two hundred in all, including about a hundred and fifty Italians, were taken aboard the submarine.

The German officers took charge of the women (four altogether). Our clothes were taken from us and dried, and we were given hot tea and coffee, black bread and butter, rusks and jam. Four of our officers who were the most ill, and we four women remained in this room which served as sleeping quarters for the German officers, and dining-room for the complete crew. The officers gave up their bunks to us and the crew gave theirs to our other ranks and Italians, themselves sitting up all night. They treated us with great kindness and respect and were really sorry for our plight. The captain wirelessed for help and received a reply from Vichy France who promised to send a cruiser and two corvettes to a rendez-vous named by them, to collect

us and take us, we thought, to Dakar. With this end in view, he started to collect our life-boats together by towing them in turn to the rendezvous. He told us he had seen twenty-two life boats altogether. He gave to several boats water and coffee night and morning, and brought women on board from the boats he contacted, as well as any men who were in a bad condition. Volunteers from the strongest of those already on the submarine went into the boats in their stead, as the submarine could not carry any more in number. Every space was packed with people, and even the crew had difficulty in moving to their posts.

On Tuesday a second submarine came and took off most of the Italians, and we heard that the Vichy ships were expected on the Thursday at the latest, and that the submarine would take care of us until then. Unfortunately, on Wednesday afternoon, the submarine was sighted on the surface by an Allied plane, and two sticks of bombs were dropped. Each was a very near miss. The submarine shuddered and shook, and one compartment was damaged. It was a dreadful sensation as we knew that one direct hit could send us to the bottom. The explosions through the water were tremendous. The captain decided, naturally, that he must submerge at once, and as he could not submerge with all of us on board, he was forced to put us off into the shark-infested water. He and his commandant were genuinely distressed. He took us fairly close to two of our life-boats and then we found ourselves once again swimming for our lives. We could scarcely see the boats when we were in the water, and there was a heavy sea. One English officer helped G . . . and Squadron-Leader W. again helped me. I am a poor swimmer, and he, a magnificent swimmer but now a very sick man, gave every ounce of his strength to get me into a boat. We swam for fifty minutes. Part of the time I was towed by him and he swam for both of us, and finally about six of us reached the life-boats. Squadron-Leader W. died a few days later—a very gallant gentleman.

G . . . also reached the life-boat, and we found ourselves the only two women with sixty-six men (all British, except two Polish cadet officers) in a thirty-foot boat. They made a small space for G . . . to lie down, as she was thoroughly exhausted. She was four months pregnant and had had kidney trouble aboard the ship. She was wonderfully brave and tried so hard to be "tough". She was allowed an extra water ration daily but she needed pints of fluid, warmth and medicines. I was wearing only a petticoat when I left the submarine, but a naval rating immediately removed his own vest and gave it to me. An airman stripped off his thick grey shirt and put that on me, and in these garments only I remained for many days. G . . . was also given dry things.

An Italian submarine arrived before nightfall and picked up all the Italians from two other life-boats, and remained to watch over us all night. For a sail we had a tarpaulin life-boat cover hoisted on to an oar. The jib was made from our only two blankets. We had four oars, and for two weeks the men rowed in shifts day and night, others taking turns at the tiller, but the rowing was discontinued as they became too weak. The submarine captain had told us that the nearest land was 600 miles away, and had advised us to steer N.N.E., adding that we should never make it.

We had among our number one lieut.-colonel, the ship's doctor, an assistant ship's engineer, an electrician and the assistant purser, a squadron leader, a pilot officer and two Polish cadet officers, one lieutenant in the Fleet Air Arm, and other ranks from

all services. We had a compass but no skilled navigator. Our daily ration of food was as follows: in the morning, four or five Horlick's tablets, three chocolates, but no water; in the evening, two ships' biscuits (size of petit beurre, but very dry and hard), one teaspoonful pemmican, two ounces of water.

On Thursday morning we started to sail for the coast, as we had no idea where the rendez-vous was, nor whether the Vichy ships would keep their appointment, and so, as we had only 15 gallons of water for 68 people and a minimum of 600 miles to go, the colonel who was in charge of our boat decided that it was unwise to hang about. During the morning an American plane sighted us, circled low over us twice, flashed us a message which unfortunately no one could read, and flew off. We were jubilant and hope ran high. In a few hours a flying boat would come and pick us all up—or in a few days a destroyer would be there to rescue us. So the hopeful suggestions ran, and we believed them all in turn. Finally, however, as nothing came, we settled down, determined to make land.

The days passed in dreadful monotony. Nobody had anything to do. G . . . and I used to sit up forward, behind the sail where we had a spot of shade, for we were in equatorial waters and the sun was almost unbearable. We talked of our homes and families and friends—of what we would do when we were rescued, and when we reached home. We were always confident, and our sense of humour persisted. We saw lovely coloured fish through the transparent water, clouds of blue-green flying fish. Sharks' fins, often followed our boat, and one day several whales came quite close to us, their great bodies making a smooth green patch as they moved near the surface. Suddenly we would glimpse the dark forms half out of the water, and from time to time they noisily spouted jets of water up into the air.

All day we longed for our minute water ration, which came at five o'clock. Our worst torture was thirst. We could easily bear the lack of food but the lack of water tried us sorely. When each water ration was passed along everyone peered at it with longing as it went from hand to hand. When we received our precious portion, we took a sip, ran it round our gums and teeth, gargled with it and finally swallowed it. We repeated this until not a drop or drip was left clinging to the little biscuit tin from which we drank. After five minutes we could not tell that we had had any, so quickly did our dehydrated bodies absorb the fluid. Whenever we had a few minutes of fine rain, as occasionally happened in the very early morning, it was a pathetic sight to see all those people with their dry brown tongues out, and heads thrown back trying to catch just a few drops.

G. . . became a little weaker each day. She never suffered acutely, but just faded, and I knew that unless we were picked up she must die. As we grew weaker and our mouths more and more dry, we only spoke when necessary. We had no drugs, no stimulants, not even any oil. We all did what we could for each other, but it was very little. I lay with my arms around her throughout the night and she just stopped breathing while asleep. We held a little service for her and tried to sing a verse of "Abide with Me", but the effort was truly pathetic. They lowered her into the water—and my friend was only a lovely memory.

As our journey continued our numbers decreased. I did not actually see all of the men die, as at first we were so crowded that I had to spend all day behind the sail, but I watched them grow weaker, saw that they had not long to live, and then just found that they were no longer there. There

were others whose brains, unable to stand the strain, gave way—their cries and rambling speech were dreadful to those of us who had to listen. One wondered how long one could remain sane. Some of the lads, fearful of going mad, jumped over the side and were carried away by the tide.

We were fortunate in having a following wind all the time, and the sea in our favour and as we grew weaker we just sat or lay around, with one man keeping watch at the tiller, and endeavouring to keep on our course. After a few days we all became light-headed and were unable to sleep, but dozed lightly and dreamed always of water, cool drinks, fruit, and of rescue. Returning to consciousness after these wanderings, time and time again I thought, 'Well, thank God it's all a dream; I shall wake up in a minute and find that it is not true', and then I would feel the boat rocking, rocking, and sit up to find only miles and miles of sea and sky.

On September 27 we saw quite clearly a three-funnel vessel several miles away. We tore open a life-jacket and set fire to the stuffing, holding it aloft in a bucket as it smoked satisfactorily. Someone blew our boatswain's whistle, and one felt that all would now be well. Surely we should be seen, but she moved on and out of sight, and we sank exhausted and terribly disappointed.

One night a small flying fish came into our boat. We divided it between eight of us, and ate it with relish. We looked with longing at the numerous but elusive fish which were always to be seen swimming about the boat through the blue water. The boys made hooks and lines, but the fish were wiser and stronger than they and none was caught. Some ate barnacles from the bottom of the boat, and the skin as it peeled from sunburnt surfaces. Until they became too weak, most of the men used to go over the side for a dip once or twice a day. They used to pour water over my bare head and shoulders, and my legs, and then we used to sit during the heat of the day with our clothing soaked in water, and a cloth tied over our heads which we kept wet perpetually. I believe that in these ways water was absorbed through the skin. By night our clothing had dried on us.

Towards the end of the third week at sea, when I could no longer eat at all because I was devoid of saliva and depended for life on my water ration, we ran out of water. We had not sufficient for next day's ration. We prayed for rain, and next morning we had a torrential downpour lasting nearly six hours! We caught it in every conceivable kind of vessel as it ran from the sail and the woodwork, and how gratefully we drank! We collected six gallons in our water tanks which we kept, and rationed as before. But by this time the colonel and the doctor and most of the officers had died.

On the morning of Thursday, October 9, we saw what we took to be a destroyer on the horizon. It appeared to come a little nearer and we saw other shapes which we took to be ships of a convoy. Then, as the "ships" did not move, we knew that our prayers were answered and our dreams realized, and that ahead of us was land. By the end of the day we could make out trees and hills easily. We dropped our sea anchor for the night, and in the morning were greeted by an off-shore breeze, and we drifted slowly away from the land. Towards afternoon an on-shore breeze sprang up and we then made fairly good speed towards land. Late in the afternoon we saw a flying boat. It came towards us and we saw a Union Jack painted on its body. We waved and waved and it circled, coming lower, circled again lower still. Someone waved a handkerchief out of the cockpit, and then as the

plane flew very low a life-jacket came hurtling through the air and landed on the water just beside us. It was a superb shot. Attached was a linen bag containing some food, but unfortunately it broke loose and was carried away, although we rescued an apple, a pear and a banana. We thanked the pilot for his gift, probably his own ration for the journey. On the life-jacket was written "Help coming. You are sixty miles south of Monrovia". We had no idea where Monrovia was, but we knew what "help" was, and our hearts sang. We could see waves breaking on the shore, and spray being flung high in the air, all along the coast line except for one spot. We knew therefore that there must be rocks where the spray flew high, and sand and shingle where we saw no spray, and our boat was being blown directly towards this gap in the rocks. Night fell and we went drifting on, but could still see the great white walls of spray. At last, we were washed up on the sand by the great rolling waves. We had beached on the one spot possible, for anywhere else for miles we should have been dashed against rocks. We scrambled over the boat's side, and promptly collapsed into the shallow water as we crawled up out of reach of the tide. The ground seemed to be rocking, rocking even as our boat had rocked, and this sensation bothered us for several days. The boys collected our remaining biscuits and pemmican from the boat, and then, wet to the skin, we huddled together on the sand, giving thanks to God for the miracle He had wrought for us. Sixteen survivors out of our original sixty-eight—and the senior rank was an R.A.F. sergeant (except for one Polish cadet officer) and we had travelled 700 miles in our open boat.

The heavy scent of tropical undergrowth was in the air. Crickets were singing as I have never heard them before, and we wondered what wild animals or cannibals lurked in the bush a few yards behind us. After about twenty minutes, we saw a light approaching along the shore. Two of our boys staggered towards it and found themselves face to face with a crowd of negroes, the leader of whom flung his arms around them and said in English "Thank God—you are safe". They had watched our boat for two days and had come to search for us. They helped us to our feet, supported us, and led us to a native African village some distance away in the bush. There, the whole village came out to see us, some laughing, some crying (we were pitiful sights) and some just staring stolidly and silently. We had landed in Liberia, a Free State in West Africa, where all the town men and women speak English. These are the descendants of American emancipated Negro slaves. The people in the bush villages are the real natives, and only some of their men speak English. They made room for us to sit, and brought us oranges, huge bananas and plums which were similar to mangoes. We ate sparingly, fearing to do ourselves harm after our long fast. Then we all huddled together on the floor of a tiny room, still in our wet clothes, and lay awake until morning.

Three of our men, who could walk slowly by morning, set off with a guide to walk to Grand Bassa, a small town a few miles away, where we were told some white people lived. They went by easy stages and suddenly met some black men, who were on their way to find us, carrying food and a letter in English, promising a warm welcome if we could return with the bearers to Bassa. Our representatives did so and found three Dutch traders all bachelors living there with a few Syrians, in an otherwise purely Liberian population. They had seen a British plane that morning circling low over Bassa, and

then flying off a little way southwards. It returned and did this repeatedly, and the Dutchmen guessed that the pilot was trying to attract their attention, and that someone must be in distress down the coast in the direction in which he flew. They therefore prepared food and organised a search party, and meanwhile heard a rumour that Englishmen had landed down the coast. When our boys arrived they were given a great welcome. They had a bath, new clothes, and food. A Liberian girl even made a cotton frock for me which was ready when I arrived and fitted perfectly. They sent a sailing boat for us with a real sail and a dozen strong black sailors and two native policemen. We were carried ashore, and away to our respective billets, being shared out between three houses. I went with seven others to the large house where the two Dutchmen lived. Although none of us had ever cried from self-pity in our distress, we all shed tears as we found ourselves safe among friends.

A trawler was sent for us by the British authorities in the afternoon of the eleventh day ashore, the captain very kindly giving me his cabin. When he learned that I was trained at St. Thomas's he told me that his aunt was also a Nightingale. We were taken off by a destroyer, and once again I was given the captain's cabin and every comfort. During the evening we contacted a submarine and dropped depth charges and for the first time throughout all these experiences I was terrified. However, we reached X . . . safely and I was taken by ambulance to the lovely hospital, high on the hill, overlooking the harbour. I was very thankful when I was put to bed in the Sisters' Ward. My companion there was Matron's cousin, also a survivor from another ship, and I was sorry when she left for home a few days later, although I rejoiced for her. I stayed there six weeks, and gradually became stronger, and at last came the day which I had longed for and yet dreaded. I was taken aboard the sister ship of the one on which I had been torpedoed and the next journey of 3,000 miles in submarine-haunted waters had begun. We arrived home without further mishap.

Editor's Note: This inspiring record of courage and self-sacrifice originally appeared in the magazine published by The Nightingale Fellowship of St. Thomas's Hospital, London. The author is herself a member of the Fellowship and her modest and self-effacing story proves herself worthy of its highest traditions.

National Immunization Week

The Health League of Canada, in co-operation with provincial and local departments of health, is conducting a "National Immunization Week" throughout Canada, beginning on November 14. The campaign is directed towards the prevention of diphtheria, smallpox and whooping cough; in some provinces the campaign will include scarlet fever. This is an educational effort to inform parents as to how they may protect their children against these preventable diseases of childhood. All Canadian newspapers and the radio stations throughout the Dominion will participate and radio addresses will be given by local health officers, as well as "spot" announcements. At the suggestion of the Provincial Health Departments the prevention of smallpox is to be included in the educational campaign. Plans are under way for the distribution of coloured posters to every school in Canada; these will be provided free of charge by the Health League of Canada as part of its educational programme. Pamphlets, street car cards and posters will be made available at cost price.

Answering a Call

Dear "Newly Registereds":

So you've finished your training and passed your provincial registration examination. In other words you are an R. N. I once heard this interpreted to mean "real nurse". Have you made up your mind what you want to do? You are very fortunate for there are many doors open to you. When you were in training you probably often dreamed of what the future would hold for you but now the time has arrived to do something about it. If you haven't reached a decision and are still wavering, I want to tell you what the V.O.N. has to offer.

Photo by M alak, Ottaw

The V.O.N. is of course the Victorian Order of Nurses for Canada, a national nursing organization with headquarters in Ottawa. It has ninety-eight branches located in towns and cities across the Dominion and employs 387 nurses. In 1897 when the Victorian Order was established, there were no departments of nursing in universities and courses in public health nursing were not available but it was realized that hospital training alone was not sufficient preparation for the community nursing service the Order was organized to give. In England, Florence Nightingale had had a vision of nurses as health teachers. She gave encouragement and advice to her friend Lady Aberdeen, the wife of the Govenor General of Canada, who was primarily responsible for founding the Order and was its first president. In a letter dated May 5, 1898, she wrote, "I do rejoice at the success which has attended your efforts to initiate the plan of establishing trained district nurses in Canada." From the beginning, training centers were established to prepare nurses for Victorian Order work and they were continued until 1920 when the newly established courses in public health nursing at Canadian universities became the required preparation. To increase the supply of nurses fulfilling this requirement, Victorian Order scholarship awards were made to well-qualified nurses to assist them to meet the expense of the course. It has been one of the cardinal objectives of the Victorian Order to assist in nursing education. This has been carried out through these scholarships and also by the field experience provided to nurses through undergraduate and post-graduate affiliations.

As there has never been a time, even during the years of the depression, when the supply of public health nurses has been adequate to meet the demand, the Victorian Order has from time to time found it necessary to take measures to increase the supply and periods of training, introductory to Victorian Order work, have been given by the larger branches notably the Montreal Branch. This training has not been regarded as a course in public health nursing but rather as a preliminary to it, for the nurses accepted for this experience work

under supervision for a time and later take the full public health course at a university.

Victorian Order nurses never work alone. The service is a combination of the effort of the local nursing staff, the Board members and the National Organization. One of the interesting and stimulating features of the Order is the *esprit de corps* that permeates the organization, a feeling of belonging to something worthwhile that adds zest to the day's service.

The work is closely linked with your hospital experience because it includes the care of the sick with which you are familiar but it goes further and combines both the curative and preventive aspects of nursing. It opens up a wider field. Health teaching is a vital part of the work. In many communities the Victorian Order programme includes the various public health activities and even the newest—industrial nursing—is undertaken by several branches. In a centre where since the war the shipbuilding industry has boomed, a small town nursing service is supplied within the plant and the staff has grown from one to five nurses.

During the war years, the greater turnover in staff has increased the vacancies. We have opportunities for well-qualified public health nurses, also for those to whom nursing outside hospital walls is a new and untried experience. You will see by our notice in the advertising section of this *Journal* the address to which you may write for application forms and information.

The Victorian Order is a supervised experience, and staff work provides an opportunity to grow in your profession. Whether you remain with the Order, take up some other form of public health nursing or return to hospital work, the experience will be broadening and maturing. Recently in a letter of resignation, a Victorian Order nurse wrote: "I feel somehow that the V. O.N. has helped me grow up; certainly it made me a better nurse." Others have said that the experience has given them prestige in obtaining a new job.

If you would like to try Victorian Order work, let us hear from you. Best wishes to you in whatever your choice may be.

MAUDE H. HALL
Acting Chief Superintendent

The A.A.R.N. Appoints a Registrar

Miss Ida Johnson, president of the Alberta Association of Registered Nurses, announces that Elizabeth Pearston has been appointed registrar of the Association to succeed Mrs. Harold M. Vango who has rendered excellent service for the past twelve years. Miss Pearston was born and educated in Scotland and received her professional training in the School of Nursing of the Winnipeg General Hospital. After being associated with the teaching staff of her own School in various capacities, Miss Pearston was appointed superintendent of the Municipal Hospital in Grande Prairie, in the Peace River District. Her work there was so outstanding that, in 1934, she was mentioned in the King's Birthday Honours List and named a Member of the Order of the British Empire as representative of hospital nursing service in Alberta's north country.

Prior to accepting her new position, Miss Pearston also served for four years in Saskatchewan as superintendent of the Lady Minto Hospital in Melfort. She thus brings to her task a fund of first-hand knowledge and experience that will be of the greatest value.

Wartime Nursing in the U.S.A.

Wartime nursing is different! That inescapable fact must be generally accepted by nurses, by physicians, and by hospital administrators. Energy and emotion now spent in resistance to change must be released for the attack on war-created needs.

It is utterly impossible to provide the necessary volume of wartime nursing service on a peacetime basis. Places where nursing is going on as usual must share with others. Individual nurses who have not made adjustments should understand the necessity for their participation. Any national plan must be judged by its usefulness at the local level, that is, where nurses live and work, in the country, in the villages, towns, and cities of the nation.

Nurses have wrought many changes, but not enough, in the pattern of nursing service. "We just do the best we can" is heard more frequently than "This is our plan". Generally speaking, educational programs have received more thought than the service programs. The principles of good nursing have not changed, but nurses are learning to concentrate on the essentials. In the analysis and administration of nursing service radical changes are being made. Tremendously valuable assistance in caring for patients is being secured from volunteers as well as from paid auxiliary workers. Thus far nursing service has not been rationed; such rationing would be complicated by the differences in individual nurses and the degree of essentiality of needed services. The sharing of services is more difficult than the sharing of goods.

A critical shortage of nurses does exist in the United States. Over 36,000 nurses are now with the armed forces and the Red Cross has accepted responsibility for the recruitment of an equal number by June 30, 1944. American soldiers are receiving skilled medical care of a high order, as shown by the high percentage of recovery from injury. Skilled nursing is an important factor in such care. The very presence of nurses near the bases of military operations has repeatedly been described as a potent force in maintaining morale. There has also been an unprecedented increase in the use of civilian hospitals due to the rapid growth of group hospitalization plans and the Children's Bureau hospitalization program for the care of the families of service men.

The accompanying table is based on the national inventories of nursing resources made in 1941 and again in 1943 by the U. S. Public Health Service and offers a comparison of data for the two intervening years. The total number of nurses graduated during this period is well in excess of the number withdrawn for military service although this fact is not apparent in the inventory. The returns are incomplete because active nurses who did not return their questionnaires evidently did not realize the profound importance of the information requested. This information is the basis for present planning and for safeguarding the future.

The relatively small decrease (as shown by the table) in the number of institutional nurses is a much less significant factor in creating the serious shortage of nurses than is the increased use of hospitals. The large increase in the field of industrial nursing is, of course, not surprising. The large number of inactive nurses who reported themselves as available is encouraging. But available for what? Full-time? Part time? These nurses, and others who are still "hidden" can make a valuable contribution to our resources. Although it requires a little more planning, the service of two part-time nurses can

Summary of National Nursing Inventories made in the U.S.A.

	1941	1943
TOTAL RETURNS RECEIVED:	289,286	259,174
ACTIVE.		
Institutional	81,708	77,704
Public health	17,766	18,900
Industrial	5,512	11,220
Private duty	46,793	44,299
Other	21,276	18,476
INACTIVE BUT AVAILABLE	25,252	38,746 (of these 23,576 are married and under 40)
INACTIVE, NOT AVAILABLE	90,979	49,829
IN NURSE CORPS OF ARMY AND NAVY	6,371	36,000 (precise data not available)

equal that of one full-time one. Wartime nursing puts a tremendous burden on all the administrative nurses.

American nursing leaders were not caught off guard by Pearl Harbor. The Nursing Council for National Defense was the outgrowth of a conference called by the American Nurses Association in July 1940 for the purpose of coordinating the activities and resources of the profession. Two years later, it was incorporated as the National Nursing Council for War Service, with medical, hospital, and lay representation included in the membership. The scope of the program was expanded. Foundations and other organizations have contributed generously to its maintenance and to the development of special wartime projects, but leadership has remained in the hands of nurses.

Until July 1 of this year, the Subcommittee on Nursing of the Health and Medical Committee of the U.S.A. Office of Defense Health and Welfare Services which had been set up only a few months later than the Council, worked with nurse-employing and other agencies of the government and the American Red Cross, on the one hand, and with the profession as represented by the Nursing Council on the other. Information was quickly shared in order that new tasks could be allocated to the appropriate agency whether federal or voluntary. The effectiveness of this liaison was demonstrated when it became apparent that the nation's nursing resources could not be increased appreciably without federal aid. Successive Congressional appropriations have been secured and the U. S. Public Health Service has already disbursed the total sum of $5,300,000. Assistance had been given to 11,911 students who otherwise could not have entered nursing schools; 4,322 graduate nurses had been enabled to take postgraduate courses; and 3,662 inactive nurses had been given refresher courses. On the basis of this splendid record, the Bolton Bill was passed without a single dissenting vote. This legislation, which provides for the U. S. Cadet Nurse Corps, has been described by Surgeon General Parran as "the most important public health legislation ever passed by our Federal Government".

The nursing organizations have combined and co-ordinated their forces in the National Nursing Council for War Service. The Council has been the means of securing federal and other financial support of wartime programs.

The General Federation of Women's Clubs and other organizations have given unprecedented assistance to nursing. The Council works co-operatively with the hospital associations and with government agencies. It is now doing a considerable part of the recruitment for the U. S. Cadet Nurse Corps. It has geared its state and local councils to make effective, at the local level, the program of the new Nursing Division of the Procurement and Assignment Service. The Red Cross recruitment committees are pledged to recruit 36,000 nurses this year. The new division will determine the availability for military service or essentiality for civilian service of all nurses eligible for military service and submit such determinations to the American Red Cross for use in procurement of nurses for the Armed Forces. The Division will promote plans for maximum utiliaztion of full-time nurses and those who are able to serve only part-time; develop and maintain a roster of all graduate registered nurses, and encourage sound methods of supplementing the work of nurses with non-professional personnel.

Through the U.S.A. War Manpower Commission, nursing will not only have the benefit of the experience of medicine in the procurement and assignment of physicians, but means will be found to interpret wartime nursing to physicians and their co-operation secured in effecting desirable wartime adjustments.

Editor's Note: The foregoing statement has been issued by the Directing Board of the United States War Manpower Commission's procurement and assignment service for physicians, dentists, veterinarians, sanitary engineers, and nurses.

R.N.A.B.C. Makes a New Appointment

Alice Lilian Wright has been appointed registrar and educational advisor of the Registered Nurses Association of British Columbia. Miss Wright was born in Prince Edward Island and received her elementary education in that province. She is a graduate of the School of Nursing of the Vancouver General Hospital and holds the degree of Bachelor of Science awarded by Teachers College, Columbia University. Miss Wright has also taken a post-graduate course in pediatrics at the New York Nursery and Child's Hospital as well as the special course given at the Kenny Institute of the University of Minnesota.

Among the positions successively held by Miss Wright are the following: Night supervisor in the Children's Hos-

Photo by Chidnoff, New York

ALICE L. WRIGHT

pital, Los Angeles; head nurse in the pediatric department of the Polyclinic Hospital, New York; instructor in the Babies Hospital, New York. Previous to her recent appointment, Miss Wright was an instructor in the department of nursing of the College of Physicians and Surgeons.

The R.N.A.B.C. is indeed fortunate in obtaining the services of a nurse who is so eminently well qualified to undertake duties that require sound preparation and broad experience. Miss Wright knows British Columbia and British Columbia knows her. They will get along well together.

"I had no Shoes"

Nurses know that good news is always a tonic. Word of Allied advances has brought a nation-wide determination to work harder than ever for victory and for peace. Perhaps this is the reason for the encouraging fact that Canadians do not regard the Fifth Victory Loan as "just another Victory Loan," but rather welcome it as an opportunity to place the Allies still farther along the road to victory and the Axis correspondingly nearer defeat. But although the need for and wisdom of Victory Loan investments is definitely established, there are still a few of us who do not invest to the limit of our ability. We who are living in the comparative luxury of civilian security cannot hold back when those who are fighting for us are willingly giving everything they've got even to life itself. It is not sufficient to be able to say, "Yes, I bought a bond". Scrape up your last penny and increase your cash and instalment purchases of bonds accordingly. They will come in mighty handy one of these days.

There is an Arabian proverb which has a new and poignant meaning in these days of rationing on the home front and hand-to-hand fighting on the war front. It is one worth remembering when the Victory Loan salesman comes calling at your door: "I had no shoes and complained—until I met a man who had no feet".

"Speed the Victory" is the watchword of the day! So when you are asked to buy a bond look as cheerful as you can and dig down deep. Taxes are high and the cost of living may be soaring but work is plentiful and earnings are good. We don't want to be a killjoy but being an ancient of days we can't help remembering the slump after the last war when nurses found it pretty hard to get work. A nice fat bond was a life-saver in those dark days. If you are going to be married as soon as he comes home, you have all the more reason to save. What about that dinner set you have set your heart on. What can you spend your money on now? You can't even buy oranges, let alone marmalade, and the butter must be spread mighty thin. No trouble keeping your weight down these days. The Government does it for you. The shops may be showing pretty dresses but the stuff is a bit shoddy. Why not explore the old trunk in the basement with a view to salvage? You might find an old hat that you didn't like but that was too good to throw away. A scrap of felt and a veil is about all there is to a hat these days and this old stager belongs to a bygone day when hats were meant to cover the head. If it happens to have a bird on it you are in luck. Feathers are coming in again. Take the ancient lid to the little milliner round the corner. She will do wonders with it.

Then there are those old shoes on the top shelf of the clothes closet. There's life in them yet if you get the heels straightened. If they haven't got those silly peep toes, so much the better. If you are young and pretty (or even old but distinguished) let the permanent wave grow out a bit. Veronica Lake is doing her hair very plainly these days. If she can stand it, you can. You might even try to do without sanguinary polish and cultivate romantic pearly pink nails instead.

The Rh Factor: its Significance in Transfusion Accidents and Fetal Death

MADGE THURLOW MACKLIN, M.D., LL. D.

Landsteiner's discovery that human beings were divisible into four main groups on the basis of the presence or absence of the agglutinogens A and B, in the red blood cells, promised a surcease of the accidents which had characterised the transfusion of blood. Unfortunately this promise was not completely fulfilled. Even after the careful grouping of both donor and recipient, occasional reactions following transfusion occurred, and the further necessity of cross-matching of bloods became apparent. Even this added precaution has not eliminated all reactions following transfusion. Continued investigations on the properties of blood cells showed that agglutinogens other than those marking the groups O, A, B and AB were present. Two of these were designated M and N. No agglutinins were present in the plasma corresponding to these latter, therefore they presented, apparently, no problem in transfusion, except in the cases where repeated transfusions had been carried out, and the recipient had opportunity of developing an isoagglutinin, provided that the agglutinogen was antigenic in nature. More recent work has shown that there are still other subdivisions of the human race depending upon the presence or absence of still other agglutinogens. One of the most recent which has come into prominence is that designated as "Rh."

In 1940 and 1941 Landsteiner and Wiener described an agglutinable factor in human blood recognizable by its reactions with immune sera for blood of the Rhesus monkey. They had injected monkey blood into rabbits until the rabbit had produced an agglutinin for the cells of the monkey's blood. With the use of this immune serum they were able to show that human beings fell into two classes, those that possessed an agglutinogen in their red blood cells that reacted with the agglutinin against monkey blood, and those who possessed no such agglutinogen. They designated the newly discovered agglutinogen "Rh" (Rhesus). About 85 per cent of those investigated possessed the Rh factor, the remaining 15 per cent lacked it. Sometimes the reactions occurred better at body temperature, than at room temperature, and the agglutinins were hence designated as "warm agglutinins".

All this might seem to have little bearing upon transfusion problems, but the reverse is true. Approaching the problem from the other angle, let us look at the case reported by Levine and Stetson in 1939, of a woman who was delivered of a stillborn fetus and who was transfused with her husband's blood. Both donor and recipient were Group O, but she went into shock, developed hematuria, and finally recovered. They cross agglutinated her with 104 other Group O donors, and she agglutinated the blood of 83 of them. With only 21 was she compatible. Levine and Stetson postulated the following theory: the father of the child possessed an agglutinogen which the mother lacked; the child had inherited this agglutinogen from the father, just as the A and B agglutinogens are hereditary. In some way or other, not as yet explained, some of the blood of the fetus got into the maternal blood stream, an accident which does not usually happen. Here, because the mother lacked this agglutinogen, an antibody or agglutinin was formed in a manner similar to that in which the rab-

bit formed the antibody to the monkey's blood cells when they were injected into the rabbit. When the mother was later transfused with the husband's blood, her antibody agglutinated his red blood cells and she went into shock.

In 1941 Burnham and Levine and his co-workers reported a series of cases of transfusion accidents, all of which happened in women who had just given birth to an infant, and hence patients in whom there was presumably opportunity for an immunization to have occurred against the blood of the babies they were carrying, and, therefore, against the blood of the husbands from whom the babies had inherited an agglutinogen not present in the mothers. It is to be noted that in most of these cases the husband was the donor of the blood with which the mother was transfused. Other interesting facts began to emerge from this study. The women who had these transfusion accidents after the birth of their babies were women who had peculiar obstetric histories. Most of them were characterized by the fact that they had had one or more spontaneous miscarriages, or still births, or infants dying within a few days of birth, sometimes with fatal jaundice of the new born. At this point we have to drop the story of the Rh factor temporarily and go back some years to review the history of a disease called erythroblastosis fetalis.

As long ago as 1912, Rautmann stated that several conditions characterising the infant before or after birth were in reality merely aspects of differing severity of the same disease which he called erythroblastosis fetalis. These three conditions were hydrops fetalis, in which the fetus was born prematurely, with all its tissues and body cavities distended with fluid. The second condition, which at first sight was totally unrelated to hydrops, was fatal jaundice of the new born. In this condition the baby, usually normal at birth, began shortly thereafter to develop a jaundice which deepened, until within a few hours or at most days, the child died. Numerous infants of a mother might be lost through fatal icterus. The third condition was congenital anemia. In this, the infant would perhaps develop a jaundice which was neither so intense nor so fatal as in the second syndrome, but it developed an anemia which lasted for months, but from which it would usually ultimately recover. In all three syndromes the underlying pathological picture was one of intense destruction of the fetal red blood cells, and attempts on the part of the baby to regenerate new cells to make up for the loss.

Because of the fact that the same mother might have a series of pregnancies resulting in children with hydrops, or fatal jaundice, I became impressed with the fact that there was a genetic basis to the disease, in other words that it was inherited, and postulated that it was a dominant mutation occurring in the germ cells of one of the parents of these hydropic, or jaundiced offspring. In 1923 Ottenberg, and again in 1938, Darrow put forward the idea that the blood of the fetus in some manner got into the mother's blood stream, immunizing her against the baby's blood cells, and that the antibody diffused back again through the placenta into the baby's blood stream, where it acted upon the red cells destroying them and causing the baby to manufacture ever greater quantities of red cells, which the antibody as promptly destroyed. Therefore the baby was born either dead or alive, with evidence in most of its organs of an intense activity of the red blood cell forming organs.

The obstetric history of these mothers also interested me, for in addition to the numerous infants with fatal jaundice, and those with hydrops, these mothers had an unduly large number of miscarriages and still births, which were not reported as cases of erythroblastosis. So constant was the association of mis-

carriages and still births and macerated fetuses with the mother's history of having some children with fatal jaundice that I emphasized that these accidents of pregnancy must likewise be regarded as probable examples of erythroblastosis which had not been examined for the disease, but which were in reality affected with it as truly as were those infants which revealed outspoken hydrops, jaundice or anemia.

With the discovery of the Rh factor by Landsteiner and Wiener, and with the discovery by Levine and his coworkers that these mothers who had transfusion accidents after delivery were also mothers with obstetric histories of miscarriages, still births, children with hydrops or with jaundice, the various parts of the puzzle began to fall into an intelligible pattern. The picture seems to be as follows although this is not the whole story even yet: people are divided into two classes (1) those who have in their red blood cells an agglutinogen Rh, which can be identified when looked for by means of serum immunized against monkey blood; and (2) those who have no such agglutinogen. This agglutinogen is hereditary and can be passed on from parent to child. As with all hereditary characters, one receives something from either parent with respect to that character.

Now, if a man with Rh present in either single or double dose (Rh positive) mates with a woman who has no such Rh factor, and whom we thus call Rh negative, he passes on the Rh agglutinogen to some or to all of his children (depending upon whether the Rh factor is present in single or double dose). The blood of the Rh positive fetus may not get into the maternal blood stream and usually does not. There is thus no way of immunizing the mother against the fetal blood, since the agglutinogen seems not to be diffusible from the red cells. But if in some way (and so far it has not been explained how) the baby's Rh positive blood gets into the mother's blood stream, which is Rh negative, the mother begins manufacturing an antibody against it. This antibody appears to be capable of diffusing back again through the placenta where it destroys the red cells of the developing fetus. The latter responds by manufacturing more red cells to make up for the loss, and so the vicious circle continues, the mother's antibodies destroying the baby's cells, and the baby compensating by turning most of its energies to making more. In this process, the fetus may die, and a miscarriage results. The child may go on to almost full term, but may not be able to withstand the prolonged trial of being born, and is a still birth. It may live only to die of jaundice shortly after it is born.

The antibodies in the mother's blood stream gradually disappear, according to Levine, within a year or so, and if she does not require a transfusion, the fact that she possesses these irregular agglutinins is not known. She may become pregnant again. If the baby again inherits from its father the Rh factor, the same history may be repeated, which would indicate that in some of these mothers there seems to be a mechanism conducive to allowing the fetal blood to escape into the maternal circulation. If, however, the next baby does not inherit the Rh agglutinogen from the father, then, even if blood from the baby does escape into the maternal circulation, it makes little difference, because the baby's blood is like the mother's, Rh negative, and so no antibodies are formed. If the baby has inherited Rh from the father, and its blood does not escape into the maternal blood stream, no reaction follows.

All of this story has very important applications. The first of these is that a recipient who has never been transfused before may have antibodies against the blood of the donor who is of a compatible blood group, provided that the re-

cipient is a pregnant woman lacking the agglutinogen which the fetus carries and which is the same agglutinogen as that carried by the donor, which may or may not be the husband. Any Rh positive person is just as incompatible in such instances as is the Rh positive husband of the woman. Transfusion with such Rh positive blood may mean the death of the mother as it did in several of Levine's patients. Choice of the husband as donor is the worst possible choice under such circumstances, for it guarantees the introduction of blood containing the agglutinogen against which the mother has an antibody. Cross matching of the patient's blood with the compatible donor's blood should be carried on at body temperature because occasionally these reactions do not occur at room temperature but at body temperature. Plasma rather than whole blood should be used, thus obviating the opportunity for antibodies to destroy the donor's cells.

Not only may these reactions happen to the pregnant woman, but also to persons who have been repeatedly transfused, and who have thus had opportunity to develop antibodies. Deaths have been known to occur under these circumstances also. The obvious thing would appear to be to determine whether persons are Rh negative or positive and if possible use only Rh negative donors. This is difficult for two reasons. It is hard to distinguish Rh negative and positive persons because of the trouble in getting potent anti-Rh serum. Second, there are only 15 per cent of the population who are Rh negative, and all the donors would have to come from that class. There may well be other agglutinogens than Rh present in the red blood cells, and these also might act in a manner similar to the Rh agglutinogen causing transfusion reactions even though both recipient and donor are Rh negative.

From this story of erythroblastosis fetalis and Rh factors it would seem that the following recommendations are worth while:

1. When transfusion is necessary in a pregnant woman, or in one who has just delivered an infant, use plasma rather than whole blood, thus eliminating the opportunity of any antibodies she may have developed reacting with red blood cells to which she is immune.

2. If whole blood is used, do not use her husband as a donor even if he belongs to the same group unless the bloods are cross agglutinated for several hours in an incubator at 37°C. to rule out the presence of irregular reactions.

3. If she has a history of one or more miscarriages, for which no explanation such as proved syphilis or grossly malformed infants, is present, or if she has a definite history of having borne an hydropic infant, or a child who had icterus gravis neonatorum, then the use of her husband's blood is strongly contraindicated. About 85 per cent of compatible donors will be equally undesirable, since 85 per cent of the population carry the Rh factor.

4. Because these antibodies may persist for a year or more after delivery, the obstetric history of the patient is important before any transfusion is undertaken, in order to rule out the possibility that the patient is one who has developed antibodies against the Rh factor.

HOSPITALS & SCHOOLS *of* NURSING

Contributed by the Hospital and School of Nursing Section of the C. N. A.

Is General Staff Nursing Worthwhile?

RITA CURLEY

A remark frequently heard is that general duty is a nursing field that demands much and gives little in return. The reason for such a remark is that opportunities in that field are not fully recognized and understood. For the purpose of clarifying the subject, I will endeavour to demonstrate that general staff nursing has very much to offer professionally, that it offers enough financially, and that socially it is valuable. First and foremost, the professional opportunities are numerous. The staff nurse has a splendid chance of growing through practice, by the daily application of the principles and techniques learned as a student. She can develop high ideals of good nursing, and remain where her interests were so strongly rooted. General duty affords a wide choice as to what type of nursing is preferred. Obstetrics, pediatrics, medicine, surgery, operating room technique, the out-patient departments are all wonderful branches for specializing and the nurse may develop her capacity in one of these fields thus preparing her for future responsibilities. Exceptional advantages for further study are available in institutions, where staff education is carried on through staff conferences, refresher courses, ward rounds and extension courses.

Then, because of her close association with the student nurses, the staff nurse must develop from a good nurse to a better one. She must be a model to students, and students are the most critical of critics. To a student, a graduate nurse's work is a demonstration of perfect technique after three years preparation and a period of graduate experience. Greater enjoyment and more satisfaction are derived from these demonstrations as they give greater service to more people. The general duty nurse has every opportunity to attain technical competence because she is keeping abreast of the latest developments in medicine, new nursing procedures, new equipment, and new treatments. Her everyday work is in reality but a continuance of professional preparation.

I wish that the young graduate nurses of the future would recognize the importance and advantage of spending six months, or preferably a year, on general duty either at their own hospital or elsewhere previous to their undertaking private duty or post-graduate courses. Interesting her work is by all means! It is absorbing to associate the doctor with his patients and the diagnosis, treatments, medicines and psychological reactions form a complete picture. But in caring for more than one patient the

situations become more interesting because of the contrast in their reactions and in the adjustments which must be made to their personalities. Then there is always the opportunity of teaching patients the essentials of healthful living.

In considering the financial aspect, general duty nursing has advantages too. The salary is not large but it is sure and adequate. The general duty nurse has greater financial freedom with a regular salary and is, therefore, able to plan her budget. She does not have to worry about collection and she can enjoy a feeling of security for she knows that she will be cared for in case of illness. Living conditions are secure if she is living in, and there are no laundry bills to pay, nor telephone, no taxi fare or car fare. She may enjoy all the comfort which modern residences have to offer.

The social opportunities offered are well worth mentioning. Because of regular hours of duty, she may plan recreation and social activities and thus keep mentally refreshed and alert. Eight-hour duty also affords leisure hours for further study. Friendships become stabilized through daily association with fellow nurses and another great satisfaction is that derived in having patients come to us, as their friends, seeking help and advice.

History of the Sulphonamides

CHRISTINA SINCLAIR

Although the sulphonamides have only become familiar to us recently, the story of their development dates back thirty-four years. To be exact, it was in 1908, when Gelmo, a German organic chemist, first synthesized the basic sulphonamide. This new product was utilized in the form of basic azo-compounds in the German dye industry and it was men connected with this industry who were later to discover its anti-bacterial action. At the I. G. Farbenindustrie at Elberfeld, Germany, a research programme was carried out under the direction of Professor Haerlein. In studying the dyes, he noted that those containing the sulphonamides had a definitely superior colour-fastness which was due to their combining with the protein of the wool. Haerlein did suggest the possibility that this compound might combine with bacterial protein. In 1913, Eisenberg, another German chemist, also suggested that it might have a bacteriocidal action which would be of use in chemotherapy.

The turning point in the history of the drug, however, was 1927, for in that year Gerhard Domagk was made director of the Institute of Experimental Pathology in Germany. He, with his associates, Meitzsch and Klarer, set for themselves the task of finding a chemical which would be effective against bacteria which caused the most common infections. Great strides had been taken in surgery, in preventive medicine, and in vaccines and serum; but in the treatment and arresting of streptococcus and staphylococcus infections, comparatively little had been accomplished. And so, in 1935, Meitzsch and Klarer obtained a patent for a water-insoluble basic azo dye, sulphamido-chrysiodine (prontosil). They then carried on laboratory experiments with mice and found that they could inject the mice with fatal doses of streptococcus, follow by varying doses of the drug and the mice would "live to be experimented on again". In 1935, then, Domagk announced his discovery of a drug, neo-

prontosil, which he had demonstrated was effective against bacterial infection. In 1938 the Nobel Prize was awarded to him for this discovery.

News of the drug spread quickly. In France, Girard, Levaditi and Vaisman synthesized this new drug known there as "rubiazol". Working at the Pasteur Institute, Fourneau in his experiments found that the prontosil was reduced to free sulphanilomide and that the antibacterial action was due to the latter's properties. Though this in itself was not a startling discovery, it nevertheless led the way to far more intensive clinical studies since the use of sulphanilomide was not shackled by patent rights. In England, the Therapeutic Trials Committee investigated European reports and in 1935 synthesized the drug. In America, Johns Hopkins University was the experimental centre. Scientists such as Perrin Long, Eleanor Bliss, Mellon, Rosenthal studied the drug but were interested mainly in its chemistry.

The first clinical case study was made by Forester, on his treatment of a seven month infant, suffering from streptococcus septicaemia, with neo-prontosil resulting in a dramatic cure. In England, Colebrook and Kenny had been assigned the work of verifying the antibacterial action of the drug. For their clinical experiments they chose the Queen Charlotte Lying-In Hospital in London and, in the six months during which they carried out their clinical studies, the death rate from puerperal sepsis was reduced astoundingly. In 1936 and 1937, the drug began to be used intensively in both Europe and America. But in America an incident occurred which greatly retarded its use. Because the compound was not readily soluble, an elixir was hastily marketed. Numerous deaths resulted from its use and the drug was immediately put into disfavour. Upon investigation it was found that the deaths had been due, not to the drug, but to the vehicle—diethylene glycol. The incident was not without value, for it led to a revision of the Federal Food and Drug Act and more cautious use of the new preparations resulted.

New sulphonamide derivatives were rapidly announced. In 1938, Whitby of London, England, produced sulphapyridine, which was found to be valuable in pneumonia. Marshall produced the sodium compound which could be given intravenously, and, in 1940, sulphadiazine and sulphaguanidine became commercially available. It has been estimated that the discovery of Domagk in 1935 has been followed by the production of 5000 compounds.

Well Merited Recognition

The University of Toronto has accorded professorial rank to the five senior members of the staff of the School of Nursing as follows: professor of nursing, E. Kathleen Russell; associate professor of nursing, Florence H. M. Emory; assistant professor of nursing, Winnie L. Chute; assistant professor of nursing, Nettie D. Fidler; assistant professor of nursing, Mary B. Millman.

The granting of this status has naturally brought a degree of personal satisfaction to those who have guided educational policy and procedure in a comparatively new field of university interest, but the significance of the action is greater than that. The very fact that one of Canada's older institutions of higher learning has seen fit to grant such recognition to certain members of the profession should prove a source of stimulus to all leaders of nursing as they seek to define and to establish sound principles of preparation and practice in nursing throughout the Dominion.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

Report of Studies made by the Provincial Public Health Sections

GERALDINE LANGTON *and* LYLE CREELMAN

It will be recalled by public health nurses that at the meeting of the Public Health Section in Montreal, in June of 1942, two resolutions were passed requesting the Executive of the Public Health Section to make certain studies. These resolutions were:

1. That the Public Health Section undertake a full study of the salaries of all nurses working in public health positions in Canada, this to include a study of the possibilities of pensions and superannuation schemes.

2. That staff education, including the introduction to the specific field and a well-planned programme for the continuous education of the staff, be considered an important part of the programme of every public health nursing organization.

Accordingly a questionnaire was compiled to cover the points contained in these resolutions, and copies were sent to each Provincial Section for completion and study in their own provinces. Very shortly after this the Canadian Nurses Association, under the auspices of the Canadian Medical Procurement and Assignment Board, undertook a survey of nursing. It was, therefore, natural that the number of replies to the smaller questionnaire sent out by the Public Health Sections would be few. Twenty-nine were received, nine of which were from voluntary agencies and twenty from official, this being just 18% of the total number of replies received by the National Office in response to the larger survey. Although few in numbers there were, however, sufficient to indicate certain facts which may be expressed in general terms. It must be understood that these statements are made from the study of the twenty-nine replies only, and may not always apply in the majority of public health agencies throughout Canada.

In regard to the study of salaries and pension schemes, the material collected in the survey of the Canadian Nurses Association is to be made available, and a detailed study will be made and reported on at a later date. It is sufficient to state here that there is a wide range in salaries paid to public health nurses across Canada. For staff nurses the lowest salary mentioned was $950. per annum, and the highest $1800. The majority of agencies pay a cost of living bonus. Very few have superannuation or pension schemes, and an annual in-

crement up to a fixed maximum salary is not generally given. It was indicated, however, that the majority of nurses in agencies having no pension scheme contribute to private superannuation or pension funds. The majority of the public health agencies reporting have compulsory retirement age. This age ranges from 60 to 68 years.

Very few of the agencies state any definite policy in regard to yearly physical examinations. It would seem that the private agencies are more aware of the value of this measure of health protection for their nurses than are the public agencies. The majority of the agencies allow time for sick leave, varying from two to six weeks, with pay.

The second section of our questionnaire relates to the introduction of the new staff member and to continuous staff education. Every agency is today confronted with a major problem—that of introducing new staff members. With one exception, all indicated employment of new staff members in large numbers. Not only was this an added strain to carry until these new people gained efficiency in their services, but a strain of even greater proportion rested in the fact that almost 50% of these new employees were without public health nursing certificates or degrees. Here we have a dual problem: (a) a very rapid turn-over of public health nurses; (b) wide employment in public health fields of nurses without the necessary public health qualifications.

How is this problem being met today within our own Canadian boundaries? With two major goals in mind, namely protecting the quality of the service, and the preparation and optimal development of the new employee, let us turn our attention again to the questionnaire. We find that in the majority of agencies some one person is made responsible for the introduction of the new nurse. The official position of the person assuming this responsibility varied from the medical director to general staff nurses having the greatest experience. In two cases specialists in the educational field already in the employ of the agency were assigned this responsibility. The fact that some one person assumes full responsibility for each new nurse is indeed commendable. It leads us to believe that an introductory period composed of a well-planned programme is being systematically carried on, with the result that new nurses are rendering an adequate nursing service to the public and are themselves coached and guided to greater professional growth. But unfortunately, when the questionnaires are again studied we find certain weaknesses. Not all agencies have planned programmes that can consistently meet the needs of new employees; training centres are few and far between; nurses without the accepted public health qualifications are taking part in the introductory period. The form of introduction varied from as little as one day of observation to a full year of close supervision. It is unfortunate that one-quarter of the agencies responding found it necessary to assign to new members the immediate full responsibility of a district without close supervision.

Closely linked to a satisfactory plan for the introduction of new staff members is the agency's responsibility for continuous staff education. Here we refer to the constant study of the service for improvement or changes; and the development of responsible staff participation in the formation of policies, program, and procedures. This calls for a programme covering a period of time — one or more years — with the staff active in the planning. Reports from staff study committees or from individual studies may be regarded as part of the programme, but attendance at lectures, institutes, isolated meetings, can only be so considered when these are followed by planned staff discussion

as related to agency service. It must be remembered that the availability of university or extension courses does not relieve the agency of its responsibility in providing a programme of continuous staff education.

In directing our attention to the findings of the questionnaire we place before you some of the problems revealed through this study. A very large percentage of the agencies reported that they did not plan a programme of continuous staff education and an equal number admitted that no one staff member was responsible for guiding or co-ordinating the programme. Of those who sponsored continuous staff education, only a few indicated regular meetings. A number of agencies stated that the frequency of their meetings was dependent upon the amount of work being carried at the time. Agencies giving a rural service found difficulty in promoting any regular plans for staff members in remote or isolated districts. Where educational programmes were carried, the types given included individual and group conferences, book reviews, demonstrations, groups of lectures and institutes, special studies and reports.

If the answers which have been received in the few questionnaires are indicative of policies in public health nursing agencies in Canada, we have here indeed a matter requiring our very close attention. Each agency undoubtedly is keyed up to meet the pressure of present day needs, of unusual circumstances and difficult situations, yet no agency must ever lose sight of the advances in medicine and in public health, and each must assume its rightful responsibility in providing its staff members with an opportunity for constant professional growth so that each may make her best contribution to the field of public health.

Certain conclusions, summarized from the findings within the questionnaires, may be listed as follows:

1. There is a need for some definite plan for public health nurses in regard to superannuation and retirement.
2. Since public health nurses are members of a group teaching the value of periodic health examinations, agencies should be more definite in their policy in regard to staff members having such an examination.
3. The fact that during the past year almost 50% of the new nurse employees have received appointments without adequate public health qualifications indicates that either (a) there is an insufficient number of nurses prepared in public health; or (b) employers have not been educated to demand these qualifications.
4. There is a very definite need for systematic planning and carrying through of a programme for the introduction of the new staff member.
5. It is evident that agencies do not fully appreciate the value of a continuous programme of staff education, or realize their responsibility to the staff members for providing an opportunity for such a programme.

The Executive of the Public Health Section, in reviewing these findings, suggest that each public health nursing agency study and evaluate their own policies and procedures in relation to the above conclusions. The strengthening of any one weakness which may exist within the agency programme is a note of progress and indicates a worthwhile contribution to the advancement of public health.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Gallant Spirit

MARY MCNEE

Some people say that war has not yet come to Canadian soil but I have witnessed in the past year a fight that for sheer courage, endurance and strength of character I feel sure has not been surpassed on the battlefields. Miss X, a young woman of twenty-seven years of age, came to Ottawa to help in the war effort. With rents high, and meals in restaurants likewise, she secured lodgings quite some distance from her work and, before long, began to show signs of fatigue and therefore sought medical advice.

Miss X had previously suffered from abdominal discomfort but worried little about it. Now she became acutely conscious of the fact that attention was needed and entered the hospital suffering from pain in the right lower quadrant. She was operated upon the following morning and the appendix was found to be bound down by adhesions. The left ovary was normal but the right ovary was full of cysts, the largest being ruptured during removal, thus permitting clear fluid to escape into the abdominal cavity. There were some small fibroids on the posterior wall of the uterus.

The patient made a satisfactory recovery until the eighth post-operative day when, while the nurse was present in the ward, the patient suddenly screamed, her eyes became fixed and her head moved from side to side. She was quite cyanosed and became unconscious. The skin was cold; the blood pressure 100/70; pulse 120 and very weak; respirations 24 and rather shallow. The usual reflexes were absent in the legs. There was no pulsation below the umbilicus and it was found that a thrombosis of the lower aorta was present.

Appropriate sedation was administerd to control restlessness and oxygen was given continuously. There was incontinence of both urine and stool. The patient could be roused but, on any movement, screamed with pain. The electric baker was placed over the legs thus keeping the temperature of the bed between 90 and 100 degrees.

On the following day (May 18) the patient's legs became quite mottled in appearance. She was only semi-conscious and there was considerable twitching, headache, and excruciating pain on movement. The temperature ranged from 101 to 104 degrees; the pulse was 120 to 130 and thready. Intravenous injections of normal saline, alternating with Ringer's solution, were commenced. Heparin 10 ccs. was given every four or six hours as required, the

clotting time being checked frequently. Oxygen was discontinued. The patient was now very irrational, talking continuously and complaining of pain in the head. On May 20, the Pavex boots were applied and left on until May 24, causing intense pain. On May 26, transfusions of 500 ccs. of citrate blood were started and repeated every seven to ten days during the patient's stay in the hospital. On June 1 the administration of sulphathiazole grs. 7½ every four hours was commenced and was continued for three days.

By this time the feet had a black, withered appearance and, from the ankle to the line of demarkation below the knee, numerous blisters appeared with profuse suppuration and a foul odour. It was then decided that amputation was the only alternative. On June 4 the left leg was amputated, eight inches above the knee and the patient's condition remained critical. The glands of the neck became oedematous and radium was applied with excellent results. Owing to poor circulation, infection of the amputation site was unavoidable and irrigations were necessary. On June 17 amputation of the right leg, ten inches above the knee, was performed. The patient's condition varied very little but nevertheless improved slowly. Sulphanilamide grs. 15 was administered three times daily for three days. On June 24 all clips were removed and, since healing was retarded, certain difficulties had to be met. Both stumps were irrigated with Dakin's solution at half strength. Alphomel and starch poultices were applied with excellent results. Although the patient remained somewhat confused, her general condition improved with a gradual daily decrease in temperature. She was kept out in the fresh air as much as possible until her discharge from the hospital. By now, she was in better spirits and was looking forward to going home. On August 18 we left Ottawa by train and the patient stood the journey exceptionally well.

I have kept in touch with Miss X and, when I last heard from her, she was walking with the aid of short artificial legs with the expectation of soon using the longer ones. She has lived a lifetime in her twenty-seven years of experience and her last words to me when I took her home were: "If anyone tells you they would rather die than be like I am, tell them they are wrong. I shall carry on". I am glad to have known my patient for she has enriched my friendships and enlarged my circle of fine, dear people.

Obituaries

Florence Bossence died on June 29, 1943, in the Victoria Hospital, London, Ont. She was a graduate of the School of Nursing of the Toronto General Hospital and a member of the Class of 1931. Miss Bossence served for a time as a supervisor at the Mountain Sanatorium in Hamilton. She also engaged in private duty nursing in Toronto and in London and was on duty at the Victoria Hospital when stricken with the illness that led to her untimely death. Her home was in London, Ont., and she will be greatly missed by her many friends.

Muriel Katharine Harpell died recently at her home in Ste. Anne de Bellevue, P. Q. Miss Harpell was a graduate of the School of Nursing of the Montreal General Hospital and a member of the Class of 1938. Shortly after her graduation, she engaged in hospital service in Bermuda and, after her return to Canada in 1941, served as a special nurse in the Military Hospital at Ste. Anne de Bellevue.

Notes From the National Office

Contributed by JEAN S. WILSON,
Executive Secretary, The Canadian Nurses Association

General Meeting 1944

The next general meeting of the Canadian Nurses Association is scheduled to be held in 1944. The city of Winnipeg has been chosen as the place of meeting.

For the third time in succession, the Executive Committee is faced with proceeding with plans for a meeting of the National Organization under wartime conditions. The president of each provincial association of registered nurses attended the last meeting of the Executive Committee; therefore the officers' decision in regard to the next general meeting has the support of the provincial associations; that decision is that it seems advisable for the Association to proceed with plans for a regular general meeting and that the basis of the programme should be the more vital questions that confront the nurses of Canada at present.

The programme committee is convened by the president of the Canadian Nurses Association, Miss Marion Lindeburgh; members of the committee are: the chairmen of the Sections — General Nursing, Miss Madalene Baker; Hospital and School of Nursing, Miss Miriam Gibson; Public Health, Miss Lyle Creelman; the convener of the Committee on Nursing Education, Miss E. Kathleen Russell; the convener of the arrangements committee, Miss Ina Broadfoot; the honorary secretary, Miss Rae Chittick and the Executive Secretary, C.N.A.

The members of the arrangements committee with Miss Ina Broadfoot as convener are: the chairmen of the Sections of the Manitoba Association of Registered Nurses — General Nursing, Mrs. M. Reynolds; Hospital and School of Nursing, Miss Catherine Lynch; Public Health, Miss E. Rowlett; and the Executive Secretary, M.A.R.N.

The Manitoba Association of Registered Nurses is to be the hostess organization; convention headquarters are to be The Fort Garry Hotel. Tentatively the date of the meeting is set for several days during the latter part of the month of June 1944.

International Council of Nurses

Miss Effie J. Taylor, President of the International Council of Nurses, has announced the return of Miss Anna Schwarzenberg, Executive Secretary, to Headquarters, New Haven, Conn., following a lengthy leave of absence. In addition to Miss Taylor, the I.C.N. officers are: first vice-president, Miss B. Alexander, South Africa; second vice-president, Mlle de Joannis, France; third vice-president, Miss Grace M. Fairley, Canada; treasurer, Dame Ellen Musson, England.

The last Quadrennial Congress of the I.C.N. was held in London in 1937 and the Board of Directors has been unable to hold a regular biennial meeting since July 1939. Canadian nurses appointed in 1937 to serve on committees were: Miss F. H. M. Emory, Membership (chairman); Miss Jean E. Browne and Miss Elizabeth L. Smellie, programme; Miss E. Johns, publications; Miss Ruby Simpson, nominations; Miss Mabel F. Gray, ethics of nursing. For the past three years

Miss Edna Moore has served as chairman of the public health committee.

At the meeting of the Executive Committee of the Canadian Nurses Association in June 1943, in response to an inquiry from the President, I.C.N., the members expressed themselves in favour of the I.C.N. undertaking to resume activities as soon as possible, with assurance of Canada's most co-operative support.

Bursaries and Loans

Members of the Canadian Nurses Association who wish to enrol for post-graduate clinical courses before April 1, 1944, and who wish to apply for a bursary are reminded that application for a bursary must be made not later than October 31, 1943. Requests for bursary application forms are to be sent to the office of the provincial association of registered nurses of which the applicant is a member. Funds for this type of bursary are available from a grant made by the Federal Government to the Canadian Nurses Association for the year 1943-44. Bursaries can be awarded for study in Canada only. (Please see these *Notes* for May, p. 346 and for July, p. 475).

The loan fund of the Canadian Nurses Association is available to members for post-graduate study and experience in Canada, except when the type of course desired cannot be obtained in this country; decision for the granting of a loan for study elsewhere is determined by the loans committee. The maximum amount of a loan is five hundred dollars, free of interest for three years from date of issue; repayment is to commence during the year following completion of the course; security required is by posting a bond or by one or two guarantors; in event the recipient leaves the nursing profession for marriage, or for any other reason, before payment is completed the total balance still owing is to be repaid at once. Requests for application forms should be sent to the General Secretary, Canadian Nurses Association, 1411 Crescent Street, Montreal, P. Q. (Please see these *Notes*, April issue, p. 276).

A Treasury of Memories

These lines bring to a conclusion the contributions made to the *Journal*, under the caption of *Notes from the National Office*, by the retiring Executive Secretary. It has been an unique and very special privilege to have been associated with those members of the Canadian Nurses Association whose vision, faith and courage brought the National Organization, and later National Office, into existence. Also, it has been a privilege to serve so long with those who patterned themselves according to the inspired leadership and disciplined thinking and action of our pioneers who built the strong, solid foundation on which the C.N.A. has been developed.

To the membership at large I wish to express my gratitude for the tolerance and goodwill always shown to me; I wish to assure the members that all officers of the C.N.A. are ever aware that without the unanimous co-operation of every member little could be accomplished in organization work.

As the C.N.A. plans reorganization of National Office in readiness for post-war years, I bespeak for the newly appointed General Secretary and her assistants the same good-will and support and the innumerable pleasant relationships, national and international, which I have been fortunate enough to experience. I take with me a treasury of memories of inestimable value.

May we all be ever mindful of the words of our Founder: "Into the future open a better way". —J.S.W.

STUDENT NURSES PAGE

A Post-partum Lung Collapse

GWENDOLYN C. BAILEY

Student Nurse

School of Nursing, Homoeopathic Hospital, Montreal

When Mrs. Y was admitted to the obstetrical ward one morning, little did we think that her case would lead up to such a thrilling climax. She had a history of rheumatic fever, but there was apparently no resulting cardiac disorder. She was 29 years of age, and in excellent physical condition, with no obvious reason why her first delivery could not be a normal one. Her blood pressure was 120/80 and the fetal heart was strong at 144. Later in the morning, as her pains grew stronger, a hypodermic of heroin gr. 1/12 was given. Close watch was kept on the fetal heart and it was noted that the pulsations had dropped to 124. Hard labour pains were experienced during the long day, eased at times by sedation. By evening, the pains seemed almost more than the patient could bear, but she bravely struggled on. The membranes stubbornly refused to rupture so they were ruptured artificially and, by means of the application of low forceps and an episiotomy under cyclopropane anaesthesia, the baby was delivered. The placenta was expressed intact and although lacerations extended into the sphincter, the rectum itself was not damaged.

Immediately after delivery, Mrs. Y's condition presented no apparent cause for anxiety, but after a short while it was noted that she did not fully regain consciousness after the anaesthetic and that her respirations were shallow and irregular. The nurses apprehensively observed a peculiar cyanosis about the face. The patient was given oxygen by mask, coramine to stimulate the heart action, and an intravenous injection of strophanthin quickly to contract the heart muscle and raise the blood pressure. An ample supply of oxygen was then supplied by nasal catheter and the mask was removed. Later, Mrs. Y regained consciousness and sedatives quieted her during the night. However, on the following day her respirations were still laboured and her pulse was rapid though strong. Chest examinations were made and consultations were held, and it was concluded that the right lung had a few moist rales and was partially collapsed, accompanied by a systolic heart murmur. The diagnosis was stated as mitral stenosis and aortic insufficiency; that is, the mitral valve became puckered, hindering the flow of the blood and due to this stenosis the aorta received an insufficient blood supply for the body.

The patient was placed in an oxygen tent and the prognosis certainly was

not encouraging. Intravenous injections of 5% glucose and saline were given, fluids were forced and sedation was continued. Gradually the effectiveness of the oxygen thus administered was demonstrated. Her colour improved and, as time went on, her breathing became easier and she seemed to be rallying in spite of the fact that death had previously seemed inevitable. In all other respects her condition was satisfactory, she voided sufficiently, the fundus was firm and no untoward bleeding occurred. On the second day post-partum, Mrs. Y complained of a tightness in her throat, a numbness in her left arm and pain in the right posterior chest. Her temperature, pulse and respirations were 101^2, 110, 40. She had a dry cough and was very restless, with symptoms of claustrophobia. The sudden release of intra-abdominal pressure at delivery resulted in an excessive load on the right heart or pulmonary circulation with resultant pulmonary edema and early failure. This was so marked as to produce blockage of the bronchial system with collapse of the lung. Associated with any pulmonary collapse is pneumonites with symptoms of pneumonia as mentioned above.

Sulfadiazine was given to check an impending pneumonia and some liquid nourishment was taken. The patient was then removed from the tent for a short period each day and, by the seventh day after delivery, the oxygen therapy was discontinued, and her condition was very much improved. She was kept completely at rest, with the exception of nursing the baby at regular intervals for a short period of time. She regained her strength magnificently, and her appetite improved. She very bravely put forth all her efforts and gave full co-operation in order to regain her health. This baffling but interesting case was brought to a happy conclusion when Mrs. Y was discharged with her precious bundle fifteen days after her delivery.

From the study of this patient the facts about a lung collapse, which was of cardiac origin in this case, have been made more clear to me. The effectiveness of oxygen therapy now holds a true meaning, and the use of the sulfa drug was proven indispensable. Last but not least, I have learned that steadfast determination and confidence must be inspired in the patient by the nurses in order to enable that patient to have complete confidence in herself. From the attending obstetrician I have learned that the recovery of the patient has been complete with apparently normal lung function, but of course the rheumatic heart is still present and the prognosis should be guarded.

Nurses Behave Like Human Beings

A good nurse has a reverence for good bedside care. Many a one has cried as she gave up general duty, "I can't go on neglecting patients!" These nurses feel that this constant overloading has taken all the dignity and much of the incentive out of their work; that it bespeaks a low value of the bedside worker. Instead of being professional women nursing patients, they become flying robots doing things to people.

There is no harder work than hospital work; it takes heavy toll of nurses. Prewar, only the young and strong were wanted for only they could stand the gaff. Reversing the firemen's order nurses run, not walk. They have steadily been running faster in the last five years, not because of emergencies or shortages but because of budgets.

They have seen increased revenues from insured care patients go into all manner of *things* and have had to run a little faster. Yet the most important element in a service agency is service; a patient may admire a parquet floor but he carries home with him the memory of good nursing — or poor nursing. —Janet M. Geister, R. N.

IN PREGNANCY

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Preventing Oil Dermatitis

Many kinds of dermatitis are encountered in industry, one of the more familiar types being the skin infection sustained by workers in machine shops and metal cutting plants. These infections are attributed to contact with cutting oils and compounds and this article will discuss only dermatitis sustained through this medium. The information presented here has been drawn from medical literature, research departments of oil companies, manufacturing plants, safety councils, and state departments of labour.

The skin is constantly in contact with oil containing more or less solid matter in suspension and the trouble is confined almost exclusively to the hairy portions of the skin. Small black spots gradually appear in the pores surrounding hairs, and increase in size until they become blackheads. If untreated, or if the worker continues his contact with oil, the blackheads grow in size and become elevated above the surface of the skin, giving the surface a roughened appearance, with a black spot about the size of a pinhead at the apex of each elevation. Usually only the hands and arms are affected, but sometimes the thigh and abdomen become covered with these impacted sores. If the cause of irritation persists, the sores become inflamed and show reddened areas. The infection continuing, these inflamed areas become pustulated and advance to the stage of pimples; in severe cases they become boils.

The time required for the trouble to develop varies with the individual. Some workers develop blackheads within a few days after contact with the oil. The infection progresses by rapid stages until the hands and arms are covered with boils and the patient is unable to carry on his work. Others seem to be immune to the infection. Some men are subject to the blackheads but do not

get beyond that stage, no matter how severe the exposure. Men reporting for treatment are usually in one of the three following conditions: (1) the pores are enlarged and plugged up so that the blackheads dot the surface of the skin thus giving the appearance of leather in the early stages of tanning; (2) red blotches on the skin varying in size and, as inflammation continues these progress to the pimple stage although free from pus; (3) the red blotches are pustulated and are rapidly on the way to the boil stage. In this condition, the worker is unfit and usually unable to carry on his work. Occasionally there are cases where a rash or an inflamed condition appears without the plugged condition of the pores. This occurs among persons with tender skins, usually of the blond or sandy types.

All cutting oils have skin penetrative powers. This property of penetration is due to the high thermal conductivity of such oils; that is, their ability to convey heat from the point of generation to the atmosphere. The oils actually penetrate the skin through the pores. Hairy skins are much more vulnerable because of the abundance of capillary pores. In penetrating the skin through the pores, the oil carries with it the bacteria which exist on the surface. Bacteria also enter the skin through minute punctures made by metal chips which are carried in suspension by the oil. Many of these chips are too minute to be discernable by the naked eye. Dermatitis is more prevalent in hot weather or in heated working atmospheres than when men work under lower temperatures.

The sores are not always precisely similar and the bacteria are not always the same. The prevalence of sore-producing bacteria has been traced to unsanitary conditions in the plant where the oil was used. It has been found that the workmen sometimes expectorate in the

oil as it passes through the machine, or in the oil tanks. Occasionally they throw garbage or other filth and refuse into the oil or otherwise contaminate it while in use. The most practical preventative is cleanliness on the part of the workers and operators, and they should be instructed to wash as frequently as possible with pure soap and hot water and to avoid the common practice of smearing the skin with oil before washing. They should also be taught to change their clothing at least twice a week and to wear clean overalls and working clothes. Overalls should be washed at regular intervals determined by the time it takes a pair to become soiled. When clothing is saturated with oil the rubbing of the fabric allows the metal particles to abrade the skin, thus facilitating ingress of the bacteria.

Filtration and sterilization of oil is desirable because these oils and compounds when in use carry particles of metal and other foreign matter which should be removed. In most plants, the oil is first put through a centrifugal separator, purifier and clarifier. It is then heated to at least the pasteurizing temperature 140 degrees F. and held at that heat from one-half hour to two hours. A higher temperature is better if there is no bad effect on the oil. The temperature is then raised to 280 degrees F. for about two minutes, after which the oil is returned to the storage tank ready for recirculation through the piping system.

The effect of sterilization by heat is only temporary and to secure more lasting protection, the use of Kilbac No. 20 in the oil is recommended. This product is manufactured by G. H. Wood and Company. This will make heat sterilization unnecessary. Nothing, however, can take the place of filtration to remove the metal chips and dirt. Workers should be warned against wiping the hands with dirty rags which are full of metal chips. The hands and arms of

the worker should be watched closely. The first signs of rash or redness should mean a trip to the hospital for examination and treatment.

Selection of Students in Wartime

There is sound reasoning for the requirement that the candidate shall have reached the age of 18 before admission to the school of nursing. Nursing educators know that admission to a college and admission to a school of nursing are not analogous as is so often stated: the college allows further time for emotional development in the individual, while the school of nursing plunges the student, within a comparatively short time, into situations she may not be prepared to meet. Since girls are graduating from high school—and usually the bright ones—before they have attained the age of 18, the problem is what measures shall be taken to recruit for nursing this younger group. Even in peacetime there was danger of losing these younger bright girls, because in the interim of graduating from high school and reaching the age of eighteen their interests became centered on some other activity. Now this professional loss has been accentuated by the many new opportunities open to women.

Two courses of action are possible in meeting the problem. One is the provision of scholarships, if needed, for the seventeen-year-old applicant in order that she may pursue additional education. The second procedure is to admit the candidate who has not yet reached her eighteenth birthday. In schools admitting students before they have attained their eighteenth birthday, it is essential to set up checks and balances which will tend to counteract the tendencies and hazards of the lower chronological age. These checks and balances should consist of making reasonably certain that the candidate possesses all other necessary qualifications—this certainty is reached by careful scrutiny and weighing of the evidence revealed in the candidate's application, in her personality reports, in her secondary school record, in her psychometric

test reports, in her health record, and in the personal interview in instances where an interview is possible. When this evidence indicates that the candidate, who has not yet reached her eighteenth birthday, possesses a fair degree of emotional maturity and of the ability to adjust to new responsibility, that she is well-developed physically and well-developed mentally, she may, with reasonable confidence, be admitted to the school. The checks and balances, however, do not end with her admission; they should take the form of a personal guidance program and of a well-supervised clinical program once she is in the school.

Not only minimum entrance age but maximum entrance age is due for reconsideration during the emergency. The age limit in the great majority of schools is 35, although there are schools that announce the maximum entrance age as 30. The maximum age should be raised as the minimum age should be lowered, for individuals whose qualifications otherwise indicate that they are desirable candidates for nursing. A woman of forty who is in good physical and mental health who has poise and emotional stability and the necessary educational background, should not only be a good risk but may also be a potential asset for a school of nursing.

—*National League of Nursing Education Bulletin*

Victorian Order of Nurses

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Edna Dysart, a graduate of Moncton Hospital and of the public health nursing course, McGill School for Graduate Nurses, has been appointed nurse-in-charge of the Digby Branch.

Ethel Gordon, a graduate of the Winnipeg General Hospital and of the public health nursing course, University of Toronto, who previously served on the Victorian Order staff in Toronto and as nurse-in-charge of the Woodstock (Ontario) Branch, has been appointed nurse-in-charge of the Belleville Branch.

Helen Furlong, a graduate of the Univer-

sity of Ottawa School of Nursing and of the public health nursing course, McGill School for Graduate Nurses, has been appointed to the Peterborough staff.

Dorothy Crozier, a graduate of the University of Alberta Hospital, Edmonton, with Bachelor of Science in Nursing at the University of Alberta, has been appointed to the St. Thomas staff.

Eileen Willis, a graduate of the Winnipeg General Hospital and of the public health nursing course, McGill School for Graduate Nurses, and *Lillian Fryers*, a graduate of the Winnipeg General Hospital and of the public health nursing course, McGill School for Graduate Nurses, have been appointed to the Winnipeg staff.

Mrs. Jessie Mitchell, who has been on leave of absence for the past six months, has resigned as nurse-in-charge of the Brantford Branch.

Eileen Bretzlaff has resigned as nurse-in-charge of the Waterloo Branch to accept a position on the staff of the Ottawa Secondary Schools.

Lucienne Audet has resigned from the Pointe Claire Branch to be married.

Mrs. McDougal (Phyllis Lidkea) has resigned from the Toronto Staff.

Lillian Pettigrew has resigned from the Toronto staff to accept a position as health teacher in the Winnipeg General Hospital.

Catherine Murray has resigned from the Huntsville Branch to accept a position as instructress of nurses at St. Joseph's Hospital, London.

Christine MacKinnon has resigned from the Prince Albert Branch to accept a position with the Nova Scotia Department of Health.

Hilda Vohman has resigned from the Toronto staff to take up other work.

Theresa Terrien has resigned from the Sherbrooke staff to be married.

Margaret McKinnon has resigned from the Montreal staff.

Margaret Morris has resigned from the London staff to be married.

Mrs. Ogilvie (Margaret Burgess) has resigned from the Winnipeg staff.

Caroline Curry has resigned as nurse-in-charge of the Woodstock (New Brunswick) Branch to be married.

Catherine Ross has been transferred from

REGISTRATION OF NURSES

Province of Ontario

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held on November 17, 18, and 19.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

ALEXANDRA M. MUNN, Reg. N.,
Parliament Buildings, Toronto

the Winnipeg staff as nurse-in-charge of the Prince Albert Branch.

Ontario Public Health Service

Mrs. Blanche Gordon (Western Hospital, Toronto, and public health nursing course, University of Toronto) has been engaged by the Board of Health to organize a public health nursing service in Pickering Township.

Helen D. Larkin (New York Hospital and University of Toronto public health nursing course) has been engaged by the Board of Health, Kenora.

Gertrude Finnemore (Women's College Hospital, Toronto, and University of Toronto public health nursing course), formerly with the Ontario Red Cross, has accepted a position on the nursing staff of the Oshawa Board of Health following the resignation of *Jean Allison* (Regina General Hospital and University of Toronto public health nursing course) who has received an appointment in Calgary. *Mrs. S. G. Jones* (Eileen Whitmore) (Holy Cross Hospital, Calgary, and University of Toronto public health nursing course) has also been appointed to the Oshawa staff.

Mary I. Bliss (Diploma Course, University of Toronto School of Nursing) has resigned from the Board of Health, Port Arthur, and is now on the nursing staff of the Board of Health, Hamilton. She will be succeeded in Port Arthur by *Elsie M. Wright* (McKellar Hospital, Fort William, and University of Toronto public health nursing course).

Eileen Bretzlaff (Civic Hospital, Ottawa, and McGill School for Graduate Nurses public health nursing course) has been appointed as the fourth nurse on the Secondary School Health Staff in Ottawa.

Elma M. Ward (B.Sc. University of Western Ontario), formerly engaged by the Ontario Red Cross and Board of Health of Dryden, has resigned to accept a position in Crowland Township.

Mrs. Walter Best (Mary E. Stewart) (Hamilton General Hospital and Summer Course in School Nursing) has been appointed to the School Health Service in Wentworth County.

Mrs. Florence Hart has retired after a lengthy service with the Stratford Board of Health. *Mrs. Gertrude Purcell* (Toronto General Hospital and University of Western Ontario public health nursing course) has been promoted to the post of senior nurse, and *Mrs. Myrtle Graham* (Stratford General Hospital and University of Western Ontario) will be junior member of the staff.

Lottie Siegrist (Sarnia General Hospital and Summer Course in School Nursing) has been engaged to do school nursing in Thorold Township.

Hilda Vohman (Grace Hospital, Toronto, and University of Toronto public health nursing course) has been appointed by the Board of Health, Wallaceburg. *Jean Birch* (Toronto General Hospital and University of Toronto public health nursing course) has resigned.

Glenna French (General Hospital, Pembroke, and Summer Course in School Nursing) has been given leave of absence from the United Counties Health Unit and will take the course in public health nursing at the University of Toronto commencing this Fall. She will be replaced by *Irene Martin* (Hotel Dieu, Cornwall, and McGill School for Graduate Nurses public health nursing course).

NEWS NOTES

BRITISH COLUMBIA

KAMLOOPS:

Many important topics were discussed at a recent meeeting of the Kamloops-Tranquille Chapter of the R.N.A.B.C. The president, Miss Olive M. Garrood, was in the chair and Miss Evelyn Mallory was the guest of honour. Miss Garrood referred to the discussion that had arisen in the Provincial Legislature when amendments to the Act were proposed but were tabled until the next session. The consensus of the meeting was that junior matriculation (and not high school graduation) should be the minimum standard of educational requirement for entrance to schools of nursing. Among the reasons for this decision were: (1) high school graduation standards vary with the individual school instead of being a province-wide standard; (2) students would have to decide on their life work at an age when they are apt to change their minds frequently; (3) the high school graduation standard permits, but does not oblige, the student to take science courses whereas a basic scientific preparation is necessary before the student can undertake specialized subjects in the nursing curriculum; (4) graduate nurses with a high school graduation certificate would be unable to proceed further in their chosen work because university post-gradute courses demand junior matriculation. With the present emphasis on health insurance, public health nurses will be needed in greater numbers than ever before and all students should have an equal opportunity to pro-

ceed with their education if they wish to do so.

MANITOBA

Winnipeg General Hospital:

Allison Roberts is now serving on the staff of the Winnipeg City Health Department. Anne Carpenter has returned to the W.G.H. as science instructor. Miss Carpenter was instructing formerly at the Children's Hospital, Winnipeg. Penelope Bonner, formerly on the staff of the W.G.H., has recently joined the Nursing Service of the R.C.A.M.C.

ONTARIO

***Editor's Note*: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.**

Districts 2 and 3

Brantford:

The nurses of Brantford have now organized a central registry with Edith Miller in charge. Twenty-four hour services for both registered nurses and doctors is afforded and it is hoped to expand this to include practical nurses and visiting housekeepers in the near future. Dora Arnold is the able chairman of the Board.

Eight-hour duty has now been instituted for the private duty nurses and seems to be enjoyed gratefully.

The new officers for the year 1943-44 of the Brantford General Hospital Alumnae Association are as follows: honourary president, E. M. McKee; president, H. Cuff; vice-president, L. Raines; secretary, O. Plumstead; treasurer, Mrs. O. Cronkwright; press representative to *The Canadian Nurse*, D. Herson; social committee: Mmes R. Brittain, W. Proctor; representative to the Local Council of Women, Mrs. F. Tomlin; gift committee: K. Charnley, J. Landreth, E. Hounslow; flower committee: L. Burtch, M. Pickersgill.

QUEBEC

Montreal General Hospital:

Norena Mackenzie has been appointed by the A.R.N.P.Q. to be travelling instructor of nurses in the Province of Quebec. Misses McEwen and Starkey have been appointed as Nursing Sisters in the R.C.A.M.C. Miss Knowlton has been appointed to the R.C.N. Nursing Service. Mrs. Annable (Miss Belfort) is in charge of the clinic at the Canadian Ordnance Corps in Montreal. Letters have been received recently from Elenora Williams who is with the American Army Nursing Service somewhere in Australia and from Meredith Bennett and Miss Cerat in North Africa.

Royal Victoria Hospital:

Clara Preston has returned to Canada after spending several years in China. Mrs. Catherine Thomas who has had charge of Ward J is now assistant supervisor in the Ross Pavilion, replacing Geneva Purcell who is taking the course in administration at the McGill School for Graduate Nurses. Eileen O'Brien, Naisi Gordon and Helen MacLaggan have joined the Nursing Service of the R.C.A.M.C. Margaret Woolner has joined the Nursing Service of the Royal Canadian Navy. Edith Miller, Vera Young, M. O. Macdonald and Mary Goodfellow are doing general duty in the Montreal Neurological Institute. Jean Hill, Eva Keilson, Dorothy Devlin, Kathleen Oulton and Mrs. D. S. Milligan (Marjorie Ashton) are taking post-graduate courses at the McGill School for Graduate Nurses. Bernice White has joined the staff of the Alexandra Hospital.

McGill School for Graduate Nurses:

The students of the Class of 1942-43 have accepted the following appointments: *Graduates of the course in administration in hospitals and schools of nursing*: Helena Reimer, to the staff of the Winnipeg General Hospital; Louise Bartsch, to the staff of the Royal Edward Laurentian Hospital, Ste. Agathe des Monts; Jane Stephenson, to the staff of the Saint John General Hospital; Margaret Wallace, to the staff of the Royal Columbian Hospital, New Westminster. *Graduates of the course in teaching and supervision*: Cora Barber, to the Children's Hospital, Winnipeg; Gertrude Callin, to the Winnipeg General Hospital; Joan Cameron, to the Hospital for Sick Children, Toronto; Anna Christie, to the Montreal General Hospital; Agnes Crigh-

ton, to the Brandon General Hospital; Evangeline Dumont, to the Montreal Children's Hospital; Ruth Farnsworth, to the Saskatoon City Hospital; Edna Felsing, to the Jeffery Hale's Hospital, Quebec City; Dorothy Gill, to the Victoria General Hospital, Halifax; Mary Harling, to the Royal Victoria Hospital, Montreal; Katharine Kindle, to the Alexandra Hospital, Montreal; Helen King, to the Vancouver General Hospital; Grace Martin, to the Jeffery Hale's Hospital, Quebec City; Edith Mewhort, to the Regina General Hospital; Rachael Resch, to the Regina General Hospital; Linda Russell, to the Moncton Hospital; Beryl Seeman, to the Winnipeg General Hospital; Edith Simms, to the Montreal General Hospital; Helen Talbot, to the Nicholls Hospital, Peterborough; Lily Turnbull, to the Regina General Hospital; Margaret Wilker, to the Saskatoon City Hospital. *Graduates of the course in public health nursing*: Marjorie Fryers, to the Victorian Order of Nurses, Montreal; Helen Furlong, to the Victorian Order of Nurses, Peterborough; Margaret Hodgson, to the Provincial Department of Health, Alberta. Elaine MacArthur, to the Halifax Health Department; Evelyn MacKinnon, to the Victorian Order of Nurses, Montreal; Alberta Normandin, to the Provincial Health Department, Saskatchewan; Helen Perry, to the Child Welfare Association, Montreal; Elizabeth Barry, to the Child Welfare Service, Saint John, N. B.; Cathryn Cummings, to the Victorian Order of Nurses, Toronto; Marion De Long, to the Victorian Order of Nurses, Halifax; Rita Doyon, to the Lake St. John Power and Paper Co., Dolbeau, P. Q.; Edna Dysart, to the Victorian Order of Nurses, Digby, N. S.; Agnes Seiferling, to the Provincial Health Department, Saskatchewan; Florence Stratton, to the Social Service Department, Winnipeg General Hospital; Ann Sumka, to the Winnipeg Health Department; Mrs. Ruth Villeneuve, to the Victorian Order of Nurses, Cornwall; Elizabeth Wallwork, to the Provincial Health Department, Alberta; Eileen Willis, to the Victorian Order of Nurses, Winnipeg.

Jessie Cook (T. & S., 1941) has resigned from the staff of the Woman's General Hospital, and is now on the teaching staff of the Royal Victoria Hospital, Montreal; Jessie Morris (P.H.N., 1941) has resigned from the staff of the Victorian Order of Nurses, Montreal; Eleanor Martin (T. & S., 1941) has resigned from the staff of the Royal Victoria Hospital, Montreal.

Recent visitors to the School included: Helen MacKay (T. & S., 1939) who is now at the Royal Inland Hospital, Kamloops; Helen Smith (Teaching, 1933); Kathleen Weatherhead (T. & S., 1942); Laura Lamb (T. & S., 1936); Helen Saunders (P.H.N., 1936).

Official Directory

International Council of Nurses

Executive Secretary, Miss Anna Schwarzenberg, 310 Cedar Street, New Haven, Connecticut, U. S. A.

THE CANADIAN NURSES ASSOCIATION

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Numerals indicate office held: (1) *President, Provincial Nurses Association;* (2) *Chairman, Hospital and School of Nursing Section;* (3) *Chairman, Public Health Section;* (4) *Chairman, General Nursing Section.*

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Ontario: (1) Miss Mildred I. Walker, Institute of Public Health, London; (2) Miss Dora Arnold, Brantford General Hospital; (3) Miss Winnifred Ashplant, 807 Waterloo St., London; (4) Miss Stella Murray, Niagara-on-the-Lake.

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Saskatchewan: (1) Miss M. R. Diederichs, Grey Nuns' Hospital, Regina; (2) Miss Ethel James, Saskatoon City Hospital; (3) Miss Mary E. Brown, 5 Bellevue Annex, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

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. . . OFF . . . DUTY . . .

It so happens that an English friend of ours makes an honest living by collecting and mounting rare wild flowers . . . for use in herbariums (or is it herbaria?) . . . Armed with the paraphenalia of her craft . . . she sallies forth in all sorts of weather . . . clad in a shabby coat and a dreadful old hat . . . to explore old and remote places . . . far from the haunts of men . . . Usually she returns about tea-time . . . cold, tired and empty-handed . . . but there are red-letter days when she discovers something frail and exquisite hidden in the crevice of a rock or blooming in the shadow of a hedge . . . The other day she happened to be in London . . . and while traversing Trafalgar Square . . . glanced at the sandbags which protect a famous monument . . . One of the bags was torn and out of the spilt earth a tiny flower was blooming that she had sought for years but never found . . . Since it was growing in the public domain . . . she decided it was a case of "finder's keepers" . . . Taking a hasty look around . . . to make sure she was unobserved by a stalwart member of the Metropolitan Police Force who was patrolling his beat in the vicinity . . . she bent over and in the twinkling of an eye transferred the treasure to her handbag . . . This story goes to prove that collector's luck is where you find it . . . Rare and delicate things appear in unexpected places . . . and may even flourish in the desolation that follows catastrophe . . . Our friend also told us that some flower . . . that seems to be a close relation of our good old Canadian fireweed . . . is growing in wild profusion over the open space that now surrounds St. Paul's Cathedral . . . We can't be positive about the botanical accuracy of this statement because she dignified the homely weed by giving it a Latin name we couldn't decipher . . . Anyway we like to think that, with characteristic Canadian audacity, fireweed may be flaunting its magenta blossoms over what was once a London slum . . . but is soon to be converted into a pleasant open space with grass and trees . . . to replace the shabby huddle of ugly houses that used to hide the majesty and beauty of the great Cathedral . . . When that day comes, the fireweed will have to be rooted up . . . but it will have done its pioneer work just as it does in our fire-swept forests in Canada . . . In among the blackened stumps, and before anything else takes root, it manages to make a thrifty living out of the scorched and barren soil . . . Every Spring it comes up anew . . . and in the Autumn flings its prodigal seed into the air . . . Presently other and less hardy growth takes heart of grace and challenges its supremacy . . . Blueberry patches begin to form . . . the wild azalea that we used to call Hudson Bay tea clusters round the rotting stumps . . . a few birds come to feast on the berries . . . and the wind carries the floating thistledown of the poplars . . . A few little trees spring up here and there . . . slowly the forest comes into its own again . . . but the fireweed was there first . . . to prepare the way for it . . .—E.J.

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NOVEMBER
1943

THE CANADIAN NURSE

Red Cross Outpost
rse is a Welcome
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an Red Cross Society

See Page 712

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(1) 1938, Am. J. Diseases Children 55, 1158.
1939, Hygeia 17, 171.
1940, Calif. and Western Med. 53, 18.
1941, J. Am. Dietet. Assn. 17, 861.
1941, Arch. Pediatrics 58, 40.

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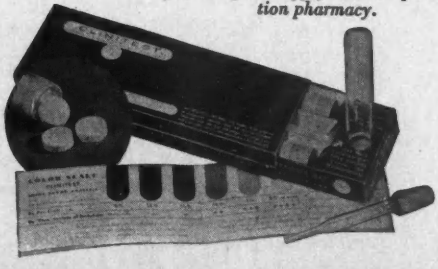

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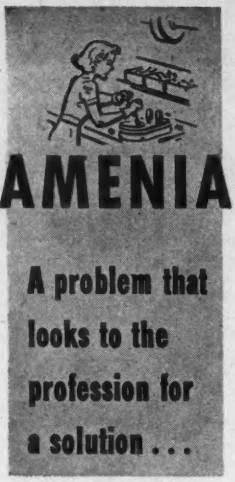

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